TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0210.000 GENERAL RULES AND PRINCIPLES

	Section	Page
Principles of Medicaid Eligibility Determination	M0210.001	1
Ineligible Persons	M0210.100	2
Classification of Cases	M0210.200	3

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

General Principles	M0220.001	1
Citizenship and Naturalization	M0220.100	2
Alien Immigration Status	M0220.200	3
Full Benefit Aliens	M0220.300	7
Emergency Services Aliens	M0220.400	17
Aliens Eligibility Requirements	M0220.500	20
Full Benefit Aliens Entitlement & Enrollment	M0220.600	22
Emergency Services Aliens Entitlement & Enrollment	M0220.700	23

Appendices

INS District Offices	Appendix 1	*1*
Document Verification Request (Form G-845)	Appendix 2	*1*
Document Verification Request Supplement (Form G-845 Supplement)	*Appendix 2a*	*1*
Alien Codes Chart	Appendix 3	*1*
Emergency Medical Certification (Form 032-03-628)	Appendix 4	*1*
Sample letters of Certification/Eligibility for Victims of a Severe Form of Trafficking	*Appendix 5*	*1*
SSA Quarters of Coverage Verification Procedures	*Appendix 6*	*1*

M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

Policy Principles	M0230.001	1
Definition of Terms	M0230.100	1
Residency Requirements	M0230.200	2
Specific Prohibitions	M0230.300	6
Disputed Residency	M0230.400	7

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

General Principle	M0240.001	1
Application For SSN	M0240.100	1

M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS

	Section	Page
General Principles	M0250.001	1
Condition of Eligibility	M0250.100	1
Procedures for Assignment of Rights	M0250.200	2
Pursuit of Support From the Absent Parent	M0250.300	3
Determining Parent's Absence	M0250.400	4
Support From the Absent Parent	M0250.500	5

Appendices

Notice of Cooperation and Good Cause	Appendix 1	1
Good Cause Determination	Appendix 2	1
Absent Parent/Paternity Information	Appendix 3	1
Medicaid Information Transmittal	Appendix 4	1

M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

M0270.000 APPLICATION FOR OTHER BENEFITS

General Principle	M0270.100	1
Types of Benefits	M0270.200	2
Agency Procedures	M0270.300	3

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

General Principles	M0280.001	1
Definition of Terms	M0280.100	1
Institutional Status Rule	M0280.200	3
Inmate of A Public Institution	M0280.300	5
Procedures For Determining Institutional Status	M0280.400	9
Individuals Moving To or From Public Institutions	M0280.500	10
Departmental Responsibility	M0280.600	11

M0290.000 HIPP REQUIREMENTS

General Principles	M0290.001	1
Definition of Terms	M0290.100	1
HIPP Requirements	M0290.200	2

M0210.000 GENERAL RULES & PROCEDURES

M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all possible covered groups and categories, and the applicant/recipient shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

a. Citizenship/alien status (M0220).
b. Virginia residency (M0230).
c. Social security number provision/application requirements (M0240).
d. Assignment of rights to medical benefits *and pursuit of support from the absent parent* requirements (M0250).
e. Application for other benefits (M0270).
f. Institutional status requirements (M0280).
g. Application to the Health Insurance Premium Payment Program (HIPP) (M0290).
h. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

a. Asset transfer *(subchapter M1450 for all individuals)*.

b. Resources within resource limit appropriate to the individual's covered group. (chapter M06 for F&C covered groups; chapter S11 for ABD covered groups).

c. Income within income limit appropriate to the individual's covered group. (chapter M07 for F&C covered groups; chapter S08 for ABD covered groups).

EXAMPLE #1: On July 5, 1996, Mr. H applies for Medicaid. He is in a nursing facility in Virginia. When evaluating his application, the worker finds that he:

- is a U.S. citizen,
- is currently a Virginia resident residing in a medical institution in Virginia,
- refused to provide his Social Security number,
- refused to provide third party liability and medical support information,
- has applied for all benefits to which he is entitled,
- meets the institutional status requirements,
- is not required to apply to the HIPP Program,
- is age 67 years and meets a covered group requirement.

He currently has $5,000 in the bank. His income is $600 per month Social Security (SSA). He is ineligible and his application is denied because he does not meet the Social Security number and the assignment of rights requirements. He is also informed of the resource limit and that he is ineligible for Medicaid because his resources exceed the limit.

M0210.100 INELIGIBLE PERSONS

A. Introduction

The individuals listed in this section are not eligible for Medicaid. However, their income and resources may be considered in determining the eligibility of others in the household who have applied for Medicaid.

B. Certain Recipients of General Relief (GR)

A recipient of General Relief maintenance who does not meet a Medicaid covered group is not eligible for Medicaid.

An applicant for Medicaid and SSI who receives GR from the interim assistance component may become eligible for Medicaid following the establishment of SSI eligibility. Eligibility for an SSI payment is effective the month **following** the SSI application month. When the Medicaid application is dated in the same month as the SSI application, Medicaid eligibility can be effective the month of application if the applicant meets all Medicaid eligibility requirements and another covered group requirement in the application month.

C. Essential Spouse of an ABD Individual

An essential spouse of an aged, blind, or disabled person who does not himself/herself meet a covered group is not eligible for Medicaid.

D. Individual Who Refuses to Assign Rights

An individual, who refuses to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.

E. Individual Who Refuses to *Pursue* Support *From an Absent Parent*

An individual, other than a *medically indigent* pregnant woman, *applying for Medicaid for herself and on behalf of a child who refuses to cooperate in the pursuit of support from an absent parent, is not* eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.

F. Individual Found Guilty of Medicaid Fraud

An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.

G. Individual Who Has Transferred Property

An individual who transferred property:

- to become or remain eligible for Medicaid,
- who did not receive adequate compensation, and
- who did not meet one of the asset transfer exceptions

is *ineligible for Medicaid or Medicaid payment for long-term care services* for a specified period of time unless *adequate* compensation is received before the time period is over. See *chapter M1450* for asset transfer policy.

H. Individual Who Refuses to Supply or Apply For Social Security Number

Any individual, except a child under age 1 born to a Medicaid-eligible mother or an illegal alien, who does not apply for a Social Security account number (SSN) or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for Medicaid.

M0210.200 CLASSIFICATION OF CASES

A. Introduction

An individual who meets the nonfinancial eligibility requirements must meet a classification and covered group in order to be eligible for Medicaid. Medicaid eligible individuals fall into four classifications:

1. Categorically Needy
2. Categorically Needy Non-money Payment
3. Medically Needy
4. Medically Indigent

Within each classification are several covered groups of eligible individuals. See chapter M03 for the covered groups' policy and procedures.

CHAPTER MO2
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 20

CITIZENSHIP & ALIEN REQUIREMENTS

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

	Section	Page
General Principles	M0220.001	1
Citizenship and Naturalization	M0220.100	2
Alien Immigration Status	M0220.200	3
Immigration Status Verification	M0220.201	3
Systematic Alien Verification for Entitlements (SAVE)	M0220.202	5
Full Benefit Aliens	M0220.300	7
Aliens Receiving SSI	M0220.305	8
Certain American Indians	M0220.306	9
Qualified Aliens Defined	M0220.310	9
Veteran & Active Military Aliens	M0220.311	12
Qualified Aliens Who Entered U.S. Before 8-22-96	M0220.312	14
Qualified Aliens Who Entered U.S. On/After 8-22-96	M0220.313	14a
Grandfathered Aliens	M0220.314	14c
Emergency Services Aliens	M0220.400	17
Unqualified Aliens	M0220.410	18
Qualified Aliens Who Entered U.S. On/After 8-22-96	M0220.411	19
Aliens Eligibility Requirements	M0220.500	20
Full Benefit Aliens Entitlement & Enrollment	M0220.600	*22a*
Emergency Services Aliens Entitlement & Enrollment	M0220.700	23

Appendices

Immigration and Naturalization Service (INS) Offices	Appendix 1	1
Document Verification Request (Form G-845)	Appendix 2	1
Document Verification Request Supplement (Form G-845 Supplement)	Appendix 2a	1
Alien Codes Chart	Appendix 3	1
Emergency Medical Certification (Form 032-03-628)	Appendix 4	1
Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking	Appendix 5	1
SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents	Appendix 6	1

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non citizens of the U.S.. These changes eliminated the permanently residing under color of law (PRUCOL) category of aliens. The level of Medicaid benefits for aliens is based on whether the alien is a "qualified" alien and the alien's date of entry into the U.S.

As a result of these federal changes in Medicaid eligibility for aliens, the 1997 Virginia General Assembly enacted legislation to protect Medicaid eligibility for certain aliens who would otherwise lose their Medicaid benefits.

This subchapter (M0220), *effective on July 1, 1997*, explains in detail how to determine if an individual is a citizen or alien *eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). It* contains the entitlement and enrollment procedures for *full benefit aliens and emergency services* aliens who meet all other Medicaid eligibility requirements.

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member.

If there are no adult family members, the person signing the application may sign the "Declaration of Citizenship or Alien Status" *portion* for himself/herself and all other family members.

EXCEPTION: An individual who is *an "unqualified"* alien *(as defined in section M0220.410)* does NOT complete the declaration.

The declaration is signed at the time of application. If there is no signed declaration in the case record at redetermination, one must be secured at that time. When individuals are added to an existing assistance unit the declaration must be signed when assistance is requested. As long as the signed declaration reflects the correct status of an individual, only one declaration is needed for the life of the case record.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for *any* Medicaid *services.*

C. Procedures

The policy and procedures for determining whether an individual is a citizen or a "full benefit" or an "emergency services" alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status;
M0220.300 Full Benefit Aliens;
M0220.400 Emergency Services Aliens;
M0220.500 Aliens Eligibility Requirements;
M0220.600 Full Benefit Aliens Entitlement & Enrollment;
M0220.700 Emergency Services Aliens Entitlement & Enrollment

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

A citizen or naturalized citizen of the U.S. meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

B. Procedures

1. Individual Born in the U.S.

An individual born in the United States, any of its territories (Guam, Puerto Rico, U.S. Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is presumed to be a citizen unless there is reason to question. If questionable, citizenship is verified by the individual's birth certificate or U.S. Passport. If such documents are not available, a signed statement of another person attesting to the individual's place of birth if in the U.S. is acceptable verification.

2. Individual Born Outside the U.S.

a. Individual Born of *or Adopted by* U.S. Citizen Parents

A child or individual born outside the United States of U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. *A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child. Individuals who have acquired automatic citizenship do not need to apply for citizenship.*

b. Individual Born of Naturalized Parents

A child born outside the United States of alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

c. Naturalized Individual

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above, must have been naturalized to be considered a citizen.

3. Verification

For an individual born outside the U.S. other than an adopted child, citizenship is verified by a certificate of derivative citizenship, passport, naturalization papers, or document issued by a U.S. Embassy or Consulate attesting that the person is a U.S. citizen born abroad, such as Form FS-240, "Report of Birth Abroad of a Citizen of the U.S." or Form I-97 "Consulate Report of Birth or Certification of Birth." If such documents are not available, citizenship must be verified through the nearest U.S. Citizenship and Immigration Services (USCIS), formerly known as Immigration and Naturalization Service (INS). Locations and telephone numbers are:

Norfolk Commerce Park
5280 Henneman Drive
Norfolk, Virginia 23513
Telephone – 1-800-375-5283

2675 Prosperity Avenue
Fairfax, Virginia 22031
Telephone – 1-800-375-5283

For a legally adopted child born outside the U.S., citizenship is verified by the adoption papers and verification of lawful permanent resident status at the time of adoption.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the USCIS and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document or a photocopy. Submission of just an alien number is NOT sufficient verification.

If the alien

- has an alien number but no *USCIS* document, or
- has no alien number and no *USCIS* document,

use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

Verify lawful permanent resident status by an Alien Registration Receipt Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on form I-94.

Verify lawful admission by an Alien Registration Receipt Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

Form I-151, Form AR-3 and AR-3a are earlier versions of the Alien Registration Receipt Card. An alien with one of the older cards who does not have an I-551 should be referred to *USCIS* to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-755-0777.

C. Letters that Verify Status

The *USCIS* and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with *USCIS* forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For *USCIS* letters, contact the local *USCIS* office for assistance in identifying the alien's status (see Appendix 1 of this subchapter). For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 5 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

Some *USCIS* offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an *USCIS* form. If there is any question as to the veracity or status of the document, contact *USCIS*.

E. Expired or Absent Documentation

If an applicant presents an expired *USCIS* document or is unable to present any document showing his/her immigration status, refer the individual to the *USCIS* district office to obtain evidence of status **unless** he/she provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his or her identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551, follow procedures for initiating a secondary verification.

If the alien does not provide verification of his/her identity, his immigration status cannot be determined, and he must be considered an unqualified alien.

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the United States Citizenship and Immigration Services (USCIS).

The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

1. Primary Verification

Primary verification is the automated method of accessing the *USCIS* data bank. SAVE regulations require that automated access be attempted prior to initiating secondary verification. There are some specific instances, however, when the agency will forego the primary verification method and initiate secondary verification (see **Secondary Verification**).

SAVE is accessed by the Alien Registration Number. The alien registration number begins with an "A" and should be displayed on the alien's *USCIS* document(s).

SAVE is accessible either by the local agency directly or through regional office contact. A primary verification document must be **initiated prior to case approval.**

Information obtained through SAVE should be compared with the original *USCIS* document. If discrepancies are noted, the secondary verification process must be initiated. No negative action may be taken on the basis of the automated verification only.

The primary verification document must be filed in the case record.

2. Secondary Verification

Secondary verification is required in the following situations:

a. The alien has an alien number but no *USCIS* document, or the alien has no alien number and no *USCIS* document.

b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."

c. Discrepancies are revealed when comparing primary verification to the original immigration document.

d. Immigration documents have no Alien Registration Number (A-Number).

e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.

f. The document presented is an *USCIS* Fee Receipt.

g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

When secondary verification is required, the agency will complete the top portion of a Document Verification Request (Form G-845). Appendix 2 of this subchapter contains a copy of the form.

B. Document Verification Request (Form G-845)

If the alien has filed an *USCIS* application for or received a change in status, the application for or change in status in itself is not sufficient basis for determining immigration status. Likewise, any document which raises a question of whether *USCIS* contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with *USCIS* using the Document Verification Request (Form G-845). For an alien who entered the U.S. before 8-22-96 and whose status is adjusted to a qualified status after he entered the U.S. use the Form G-845 Supplement to request the period of continuous presence in the U.S. A copy of the G-845 Supplement (S) is in Appendix 2a of this subchapter.

Form G-845 should be completed as fully as possible by the submitting agency. It is essential that the form contain enough information to identify the alien.

A separate form must be completed for each alien. Completely legible copies (front and back) of the alien immigration documents must be stapled to the upper left corner of Form G-845. Copies of other documents used to make the initial alien status determination such as marriage records or court documents must also be attached.

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. *A photocopy of the completed G-845 form must be filed in the record as evidence that the form* has been forwarded to *USCIS.* Refer to Appendix 1 for the *USCIS* mailing address appropriate to your local DSS agency.

The USCIS maintains a record of arrivals and departures from the United States for most legal entrants, and LDSS can obtain the required information from their USCIS office. The USCIS does not maintain an arrival and departure record for Canadian and Mexican border crossers. For these immigrants, as well as immigrants whose status was adjusted and whose original date of entry cannot be verified by USCIS, LDSS will need to verify continuance presence by requiring the immigrant to provide documentation showing proof of continuous presence.

Acceptable documentation includes:

- *letter from employer*
- *school or medical records*
- *series of pay stubs*
- *shelter expense receipts, such as utility bills*

in the immigrant's name that verify continuous presence for the period of time in question.

C. Agency Action

When the primary verification response requires the eligibility worker to initiate a secondary verification from USCIS, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid. Upon receipt of the G-845, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

Once information has been obtained through SAVE, aliens with a permanent status are no longer subject to the SAVE process. Aliens with a temporary or conditional status are subject to SAVE at the time of application and when the temporary or conditional status expires.

M0220.300 FULL BENEFIT ALIENS

A. Policy

A "full benefit" alien is

- an alien who receives SSI (M0220.*305*);
- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) (M0220.306);
- a "qualified" alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee, asylee, deportee, Amerasian, Cuban or Haitian entrant, or victim of a severe form of trafficking who entered the U.S. on or after 8-22-96, but only for the first **7** years of residence in the U.S. (M0220.313 C);
- a qualified lawful permanent resident who entered the U.S. on or after 8-22-96 who has at least 40 qualifying quarters of work, but only **AFTER** 5 years of residence in the U.S. (M0220.313 B);
- a qualified alien who meets the veteran or active duty military requirements in M0220.311 below; or
- a "grandfathered" alien who meets the requirements in M0220.314 below.

A full benefit alien is eligible for full Medicaid benefits if he/she meets all other Medicaid eligibility requirements.

Aliens who are not "full benefit" aliens are "emergency services" aliens and may be eligible for emergency Medicaid services only if they meet all other Medicaid eligibility requirements. See section M0220.400 for emergency services aliens.

B. Procedure

1. Step 1

First, determine if the alien receives SSI. Section M0220.305 describes this group of aliens who receive SSI.

If the alien does NOT receive SSI, go to Step 2.

If the alien receives SSI, go to Step 6.

2. Step 2

Second, determine if the alien is an American Indian born in Canada or a member of an Indian tribe as defined in section 4(e) of the Indian Self-

Determination and Education Assistance Act (25 U.S.C. 450b(e)). Section M0220.306 describes this group of aliens.

If NO, go to Step 3. If YES, go to Step 6.

3. Step 3

Third, determine if the alien is a "qualified" alien eligible for full benefits (a full benefit qualified alien).

- Section M0220.310 defines "qualified" aliens.
- Section M0220.311 defines qualified veteran or active duty military aliens.
- Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
- Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.

If the alien is NOT a qualified alien eligible for full benefits, go to step *4*.

If the alien is a qualified alien eligible for full benefits, go to step *6*.

4. Step *4*

Fourth, determine if the alien is a "grandfathered" alien. Section M0220.314 defines the grandfathered aliens.

If the alien is NOT a grandfathered alien, go to Step *5*.

If the alien is a grandfathered alien, go to Step *6*.

5. Step *5*

The alien is an "**emergency services**" alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to M0220.700 which contains the entitlement and enrollment policy and procedures for emergency services aliens.

6. Step *6*

Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien's Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.

M0220.305 *ALIENS RECEIVING SSI*

A. *Policy*

An SSI recipient meets the Medicaid full benefit alien status requirements. Some SSI recipients who are aliens would have lost SSI and Medicaid eligibility. The Balanced Budget Act of 1997 restored SSI eligibility for certain groups of aliens:

- *a legal alien who was receiving SSI on August 22, 1996, may continue to receive SSI if he/she meets all other SSI eligibility requirements.*

- an alien who was blind or disabled on August 22, 1996, and who is residing legally in the U.S. may receive SSI in the future if he/she meets all other SSI eligibility requirements.

- a legal alien who is receiving SSI for months after July 1996 on the basis of an SSI application filed before January 1, 1979, is exempted from the SSI legal alien requirements, and is eligible for SSI if he/she meets all other SSI eligibility requirements.

B. Procedure

Verify the alien's SSI current payment status on the SDX or through SVES. If the alien currently receives SSI, and/or received SSI during the period for which Medicaid coverage is requested, the alien meets the alien status requirements for Medicaid with no further development.

Determine the alien SSI recipient's Medicaid eligibility using the policy and procedures for full benefit aliens in section M0220.600 below.

M0220.306 CERTAIN AMERICAN INDIANS

A. Policy

An alien who is

- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or

- a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),

meets the Medicaid full benefit alien status requirements.

B. Procedure

Verify the status of an American Indian born in Canada from INS documents that the individual presents, or via the SAVE system.

Verify the status of a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e) from official documents that the individual presents.

M0220.310 QUALIFIED ALIENS DEFINED

A. Qualified Aliens Defined

A qualified alien is an alien who, at the time he applies for, receives or attempts to receive Medicaid is:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugee

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a **refugee under section 207 of the INA**, or an alien

who is admitted to the U.S. as **an Amerasian immigrant** pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended).

The refugee will have a Form I-94 identifying him/her as a refugee under section 207 of the INA. The Amerasian immigrant will have an I-94 coded AM1, AM2, or AM3, or an I-551 coded AM6, AM7, or AM8.

3. Conditional Entrant — an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an INS Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: Section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980.

4. Asylee — an alien who is granted asylum under section 208 of the Immigration and Nationality Act. Aliens granted asylum will have a Form I-94 and a letter.

5. Parolee — an alien who is paroled into the U.S. under section 212(d)(5) of the Immigration and Nationality Act *for a period of at least 1 year*. Aliens in this group will have a Form I-94 indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA.

6. Deportee--Deportation Withheld — an alien whose deportation is being withheld under section 243(h) of the INA (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of the INA (as amended by section 305(a)of division C of Public Law 104-208) . These aliens will have an order from an immigration judge showing that deportation has been withheld under section 243(h) or section 241(b)(3) of the INA and/or a Form I-94.

7. Cuban or Haitian Entrant — an alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980. A Cuban or Haitian Entrant is a person from Cuba or Haiti who

- has been granted parole by INS for humanitarian or public interest reasons, unless a final order of deportation or exclusion has been issued;
- has an application for asylum pending with INS, unless a final order of deportation or exclusion has been issued;

- *is subject to INS exclusion or deportation proceedings, unless a final order of deportation or exclusion has been issued.*

a. Humanitarian, Public Interest, Application for Asylum

To meet the humanitarian, public interest or application for asylum status, the Cuban or Haitian entrant must be from Cuba or Haiti and must have an I-94 with one or more of the following notations:

- *humanitarian parole;*
- *public interest parole;*
- *section 212(d)(5);*
- *parole; or*
- *Form I-589 filed.*

Contact INS if there is reason to believe that a final order of exclusion or deportation has been issued.

b. Subject to Exclusion or Deportation

To be subject to exclusion or deportation proceedings, the Cuban or Haitian entrant must be from Cuba or Haiti and must have letters or notices which indicate ongoing exclusion or deportation proceedings that apply to the individual. Contact INS if there is reason to believe that a final order of exclusion or deportation has been issued.

8. Battered Alien

an alien, and/or *an* alien parent of battered children *and/or an alien child of a battered parent* who *is* battered or subjected to extreme cruelty while in the U.S. who meets the following requirements:

a. the perpetrator is a spouse, parent or other household member of the spouse or parent's family who was residing in the home at the time of the incident but is no longer in the home. The alien must not now be residing in the same household as the individual responsible for the battery or extreme cruelty, and

- the alien was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented to or acquiesced in such battery or cruelty;

- the alien's child was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty and the alien did not actively participate in such battery or cruelty; *or*

- *the alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty while in the U.S. by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.*

b. the *agency providing benefits determines (according to the guidelines to be issued by the* U.S. Attorney General) that there is a substantial connection between the battery or cruelty and the need for benefits; *and*

c. the alien has a petition approved by or pending with INS for one of the following:

- status as an immediate relative (spouse or child) of a U.S. citizen;
- classification changed to immigrant;
- status as the spouse or child of a lawful permanent resident alien (LPR); or
- suspension of deportation and adjustment to LPR status based on battery or extreme cruelty by a spouse or parent who is a U.S. citizen or LPR alien.

M0220.311 VETERAN & ACTIVE DUTY MILITARY ALIENS

A. Veterans or Active Duty Military Aliens

An alien lawfully residing in the state (not here illegally) is always eligible for full Medicaid benefits (if he/she meets all other Medicaid eligibility requirements) **regardless of the date of entry into the U. S.**, if he or she meets one of the following conditions:

1. he/she is a qualified alien and is a veteran discharged honorably not on account of alienage, *and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code;*

2. he/she is a qualified alien and is on active duty (other than active duty for training) in the Armed Forces of the United States *(not in the Armed Forces Reserves)*,

3. he/she is the

   a) spouse or the unmarried dependent child of a living (not deceased) qualified alien who meets the conditions of 1. or 2. above, or

b) the unremarried surviving spouse of an individual described in 1. or 2. above who is deceased, if the spouse was married to the veteran

- before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or
- for one year or more; or
- for any period of time if a child was born of the marriage or was born to them before the marriage.

A divorced person is not a spouse.

A "dependent child" for this section's purposes is one whom the Veterans Administration (VA) has determined to meet the VA definition of "dependent child." According to the VA, a dependent child is an unmarried child under age 18, an unmarried child between ages 18 and 23 who is attending a VA-approved school, or a "helpless" child who became disabled before attaining age 18.

B. Verification

Acceptable verification of honorable discharge or active duty status include the following documents:

1. Discharge Status

For discharge status, an original or notarized copy of the veteran's discharge papers (DD 214) issued by the branch of service in which the alien was a member verifies whether he/she was honorably discharged for a reason other than alien status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the DD 214 form.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

2. Active Duty Status

For active duty military status, an original or notarized copy of the alien's current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty is NOT active military status), or a military identification card (DD Form 2 (active)) verifies whether the alien is in active duty military status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the current orders or military ID card.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

C. Services Available To Eligibles

A qualified alien who meets the veteran or active duty military requirements above and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

D. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for eligible veteran/active duty military aliens are found in section M0220.600 below.

M0220.312 QUALIFIED ALIENS WHO ENTERED U.S. BEFORE 8-22-96

A. Qualified Aliens--Entered U.S. Before 8-22-96

Qualified aliens (as defined in M0220.310 above) who were living in the U.S. prior to 8-22-96 and who meet all other Medicaid eligibility requirements are eligible for the full package of Medicaid benefits available to the covered group they meet.

1. Full Benefit Qualified Aliens

These "full benefit" qualified aliens who entered the U.S. before 8-22-96 are:

- Lawful Permanent Residents,
- Refugees under section 207, and Amerasian immigrants,
- Conditional Entrants under section 203(a)(7),
- Asylees under section 208,
- Parolees under section 212(d)(5),
- Deportees whose deportation is withheld under section 243(h) or 241(b)(3),
- Cuban or Haitian Entrants, and
- Battered aliens, alien parents of battered children, and/or alien children of battered parents.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.311 above, the alien is a full benefit alien.

2. Adjusted Status

When an alien entered the U.S. before 8-22-96 with an unqualified alien status and the alien's status is adjusted to a qualified status after the alien entered the U.S., the alien's qualified status is considered to be effective back to the date he/she entered the U.S. if:

- the alien was physically present in the U.S. before 8-22-96, and
- the alien remained physically present in the U.S. from the date of entry to the status adjustment date.

The date of entry will be the first day of the verified period of continuous presence in the U.S. (see M0220.202).

B. Services Available To Eligibles

A qualified alien who entered the U.S. before 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

C. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

M0220.313 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First *7* Years of Residence in U.S.

During the first seven years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). These 4 groups of qualified aliens who entered the U.S. on or after 8-22-96 are:

1. Refugees

Refugees under section 207 and Amerasian immigrants are full benefit aliens for 7 years from the date of entry into the U.S. Once 7 years have passed from the date the refugee entered the U.S., the refugee becomes an "emergency services" alien.

Refugees status is usually adjusted to Lawful Permanent Resident status after 12 months in the U.S. For the purposes of establishing Medicaid eligibility, such individuals may still be considered refugees. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-9, or RE-9.

2. Asylees

Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an "emergency services" alien.

3. Deportees

Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date witholding is granted. After 7 years have passed from the date the witholding was granted, the deportee becomes an "emergency services" alien.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.313 above, the alien is a full benefit alien.

4. Cuban or Haitian Entrants

Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an "emergency services" alien.

5. Victims of a Severe Form of Trafficking

Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children under age 18 years) issued by the ORR (see Appendix 5 of this subchapter). **The date of certification/eligibility specified in the letter is the date of entry for a victim of a severe form of trafficking.** After 7 years have passed from the certification/eligibility date, a victim of a severe form of trafficking becomes an "emergency services" alien unless his status is adjusted.

B. AFTER 5 Years of Residence in U.S.

After five years of residence in the U.S., one group of qualified aliens (as defined in M0220.310 above) who entered the U.S. **on or after 8-22-96** is eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). This group of qualified aliens who entered the U.S. on or after 8-22-96 is the **lawful permanent resident who has at least 40 qualifying quarters of work.**

1. Lawful Permanent Residents (LPRs)

When an LPR entered the U.S. on or after 8-22-96, the LPR is an **"emergency services" alien during the first 5 years** the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-9, or RE-9. Refer to M0220.313.A.1.

AFTER 5 years have passed from the date of entry into the U.S., Lawful Permanent Residents who have at least 40 qualifying quarters of work are "full benefit" aliens. Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after 5 years have passed from the date of entry into the U.S.

2. Qualifying Quarter

A qualifying quarter of work means a quarter of coverage as defined under Title II of the Social Security Act which is worked by the alien and/or

- all the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and
- all of the qualifying quarters worked by a parent of such alien while the alien was under age 18 years.

See Appendix 6 to this subchapter for procedures for verifying quarters of coverage under Title II of the Social Security Act.

Any quarter of coverage, beginning after December 31, 1996, in which the alien, spouse or parent of the alien applicant received any federal means-tested public benefit (such as SSI, TANF, Food Stamps and Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement.

C. AFTER 7 Years of Residence in U.S.

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, *or victim of a severe form of trafficking* (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

D. Services Available To Eligibles

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, *Victim of a Severe Form of Trafficking*

A qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, *or victim of a severe form of trafficking* (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, *or victim of a severe form of trafficking* who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for **emergency services only**.

2. LPR With 40 Work Quarters

After five years of residence in the U.S., a lawful permanent resident alien with 40 or more qualifying quarters of work who entered the U.S. on or after 8-22-96 is eligible for the **full package of Medicaid benefits** available to the covered group he/she meets if he/she meets all other Medicaid eligibility requirements.

E. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for full benefit qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.600 below.

The Medicaid entitlement policy and enrollment procedures for emergency services qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.700 below.

M0220.314 GRANDFATHERED ALIENS

A. Grandfathered Aliens

Certain groups of aliens who are not eligible for full Medicaid benefits because of their alien status may remain eligible or become eligible for full benefits based on the alien status requirements in effect prior to July 1, 1997. These are the "grandfathered" groups of aliens. The two grandfathered groups of aliens are:

1. Aliens in Long-term Care Receiving Medicaid On 6-30-97

All aliens receiving Medicaid and residing in long-term care (LTC) medical facilities or receiving Medicaid home and community-based waiver services on June 30, 1997, who are eligible for full Medicaid benefits on June 30, 1997, continue to be eligible for full benefits after June 30, 1997. This does NOT include aliens who were receiving Medicaid erroneously on 6-30-97.

This means that the alien had to be correctly determined eligible and actually enrolled on the MMIS on or before June 30, 1997. It does NOT include aliens whose applications were acted upon after June 30, 1997.

To be eligible for Medicaid, these aliens must continue to meet all other Medicaid eligibility requirements, including the requirement of residing in an LTC medical facility or receiving Medicaid waiver services. If the alien is discharged from LTC, he/she loses his/her status as a "grandfathered" alien forever. Even if the alien is re-admitted to LTC facility or waiver services, he is not in the "grandfathered" alien group because he lost that status when he was discharged.

Discharge from a nursing facility to a hospital is NOT "discharge from LTC" when the patient is expected to return to the LTC facility, to another LTC facility or to Medicaid CBC waiver services when the hospital stay ends.

2. Aliens Under Age 19

Aliens who are under age 19 years and who would be eligible for full Medicaid benefits if the alien requirements prior to July 1, 1997, were still in effect, are eligible for full benefits. The alien status requirements that were in effect prior to July 1, 1997, are in section B. below.

B. Alien Status Requirements in Effect Prior to 7-1-97 (For Aliens Under Age 19)

Prior to 7-1-97, aliens who had an immigration status as identified below were eligible for full Medicaid benefits if they met all other Medicaid eligibility requirements:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugees

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a refugee under any section of the INA. The refugee will have a Form I-94 identifying him/her as a refugee under the INA.

3. Conditional Entrant

an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980. Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC

1153(a)(7)) have an INS Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980

4. ***Asylee*** *an alien who is granted asylum under the Immigration and Nationality Act. These are, generally, aliens who would be otherwise deported. However, effective with the Refugee Act of 1980, asylum may be granted to an alien if it is determined that the alien is a refugee. Such asylum may be terminated if the Attorney General determines that the alien is no longer a refugee due to a change in the circumstances in the alien's country. Aliens granted asylum will have a Form I-94 and a letter.*

5. ***Parolee*** *parolees are:*

- *aliens paroled into the United States, including Cuban/Haitian entrants, pursuant to section 212(d)(5) of the INA (8 USC 1182(d)(5));*
- *admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this group, unlike refugee status, does not grant legal residence status. Parole status allows the alien temporary status until an INS determination of his/her admissibility has been made, at which time another status may be granted.*

Aliens in this group will have a Form I-94 either indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA or stamped "Cuban/Haitian Entrant (Status Pending) Reviewable [date]" "Employment authorized until [date]." Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.

6. ***Deportation Withheld*** *an alien with "deportation withheld" status is*

- *an alien granted a stay of deportation by court order, statute or regulation, or by individual determination of INS pursuant to section 245 of the INA (8 USC 1253 (a)) or INS Operations Instruction 245.3 whose departure INS does not contemplate enforcing, or*
- *an alien who is in deportation proceedings but deportation has been withheld because of conditions similar to those leading to a granting of refugee status, i.e., fear of persecution.*

Aliens in this group have been found to be deportable, but INS may defer deportation for a specific period of time due to humanitarian reasons.

These aliens will have an order from an immigration judge showing that deportation has been withheld under section 245(h) of the INA (8 USC 1253(h)) and/or a Form I-94.

7. Indefinite Voluntary Departure

aliens residing in the United States pursuant to an indefinite voluntary departure.

a. Aliens in this group are in the midst of deportation proceedings and INS, using its discretion, has allowed the alien to depart the United States voluntarily without a deportation order.

b. Aliens in this group will have a letter and/or a Form I-94 form indicating that the alien has been granted voluntary departure for an indefinite time period.

8. Immediate Relative Petition

aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure INS does not contemplate enforcing. An immediate relative for INS purposes is: husband, wife, father, mother, or unmarried child under age 21.

a. Aliens in this group are the immediate relatives of an American citizen or a lawful permanent resident and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa. If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.

b. Aliens in this group will have a Form I-94 and/ or I-210 Letter. These documents will indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, INS expects the alien's visa to be available within this time. If it is not, extensions will be granted until the visa is ready. Also indicated on these documents is the authorization for employment.

9. Status Adjustment Applicants

aliens who have filed applications for adjustment of status pursuant to section 245 INA (8 USC 1255) that INS has accepted as "properly filed" (within the meaning of 8 CFR 242.5(a) or (b)) or has granted, and whose departure the INS does not contemplate enforcing.

a. Aliens in this group have filed for lawful permanent resident status.

b. Aliens in this group will have a Form 1-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant."

10. Voluntary Departure Granted

Aliens granted voluntary departure pursuant to 8 USC 1252(b) (section 242(b) of the INA) or 8 CFR 242.5 whose departure INS does not contemplate enforcing.

a. Aliens in this group are awaiting a visa.

b. Such aliens are provided Forms I-94 and/or I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.

11. Deferred Action Status

Aliens granted deferred action status pursuant to INS operating instructions.

a. Aliens in this group are similar to those under an order of supervision except there have been no formal deportation proceedings initiated.

b. Aliens in this *group* will have a Form I-210 or a letter indicating that the alien's departure has been deferred.

12. Deportation Suspended

Aliens granted suspension of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the INS does not contemplate enforcing.

a. Aliens in this group have been found deportable, have met a period of continuous residence and have filed an application for INS to suspend deportation in an effort to be granted lawful permanent resident status.

b. If the suspension is granted, the alien must wait through two full sessions of the Congress. If the Congress does not take action on the application, INS will grant the alien lawful permanent residence.

c. These aliens will have a letter/order from the immigration judge and a Form I-94 with employment authorized for 1 year. After lawful permanent residence is granted, the alien will have a Form I-551, or I-151.

M0220.400 *EMERGENCY SERVICES* ALIENS

A. Policy

Any alien who *does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an "emergency services" alien and is eligible for emergency Medicaid services only,* if *he or she* meets all of the Medicaid nonfinancial and financial eligibility requirements.

B. Procedure

Section M0220.410 defines "unqualified" aliens.

Section M0220.411 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.

Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.

Section M0220.600 contains the entitlement and enrollment procedures for emergency services aliens.

M0220.410 *UNQUALIFIED* ALIENS

A. *Unqualified Aliens*

*Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** "grandfathered"aliens (M0220.314 above) are "unqualified" aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.*

B. Illegal aliens

Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.

C. Non-immigrant Aliens

Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are *usually* not eligible for Medicaid because of the temporary nature of their admission status *(they do not meet the state residency requirement)*. Non-immigrants have the following types of INS documentation:

- Form I-94 Arrival-Departure Record,
- Form I-185 Canadian Border Crossing Card,
- Form I-186 Mexican Border Crossing Card,
- Form SW-434 Mexican Border Visitor's Permit,
- Form I-95A Crewman's Landing Permit.

NOTE: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.

Non-immigrants include:

1. **Visitors** — visitors for business or pleasure, including exchange visitors;
2. **Foreign Government Representative** — foreign government representatives on official business and their families and servants;
3. **Travel Status** — aliens in travel status while traveling directly through the U.S.;
4. **Crewmen** — crewmen on shore leave;
5. **Treaty Traders** — treaty traders and investors and their families;
6. **Foreign Students** — foreign students;
7. **International Organization** — international organization representatives and personnel, and their families and servants;

8. Temporary Workers temporary workers including some agricultural contract workers;

9. Foreign Press members of foreign press, radio, film, or other information media and their families.

M0220.411 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First 5 Years of Residence in U.S. During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.

1. Lawful Permanent Residents (LPRs) An LPR who enters the U.S. on or after 8-22-96 is an "emergency services" alien during the first 5 years the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Refer to M0220.313.A.1.

2. Conditional Entrants A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

3. Parolees A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

4. Battered Aliens A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

B. AFTER 5 Years of Residence in U.S. **AFTER** 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:

1. Lawful Permanent Residents Without 40 Work Quarters Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S.

2. Conditional Entrants A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

3. Parolees A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

4. Battered Aliens A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

C. AFTER 7 Years of Residence in U.S.

1. Refugees — After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

2. Asylees — After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

3. Deportees — After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

4. Cuban or Haitian Entrants — After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

***D.* Services Available To Eligibles** — An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

***E.* Entitlement & Enrollment of Eligibles** — The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

A. Policy — An alien must meet all other Medicaid eligibility requirements to be eligible for any Medicaid services. The eligibility requirements are:

1. Residency — the Virginia residency requirements (M0230);

Aliens who are visitors (non-immigrants) usually do not meet the state residency requirements because their visas will expire on a definite date. Ask the non-immigrant alien "Where do you intend to go after your visa expires?" If the visitor states in writing that he/she "intends to reside in Virginia permanently or indefinitely after his/her visa expires," then the alien has stated his/her intent to reside in Virginia permanently or indefinitely and can meet the state residence eligibility requirement for Medicaid.

2. SSN — the social security number provision/application requirements (M0240);

NOTE: An illegal alien does not have to apply for or provide an SSN.

3. Assignment of Rights and Pursuit of Support from Absent Parents

the assignment of rights to medical benefits requirements (M0250);

4. Application for Other Benefits

the requirements regarding application for other benefits (M0270);

5. Institutional Status

the institutional status requirements (M0280);

6. HIPP

the application to the Health Insurance Premium Payment (HIPP) Program (M0290);

7. Covered Group

the covered group requirements (chapter M03);

8. Financial Eligibility

the asset transfer requirements (see subchapter M1450) apply.

Resources must be within the resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).

Income must be within the income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups). Spenddown provisions apply to these individuals. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.

B. Emergency Services Certification--Not Applicable to Full Benefit Aliens

Certification that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). LDSS can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.

1. LDSS Certification for Pregnancy-Related Labor and Delivery Services

LDSS can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:

- 3 days for a vaginal delivery, or
- 5 days for a cesarean delivery.

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in 2. below.

For LDSS certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates

The verification must be documented in the record.

NOTE: A child born to a woman certified for Medicaid payment for the labor and delivery is entitled to Medicaid as a newborn child (see M320.301) or as a Child Under Age 1 (M330.302) without having to file an application as long as the child continues to live with the mother.

2. DMAS Certification for Emergency Services Required

When DMAS certification for emergency services is required, the worker must obtain a signed release of information from the applicant and request evidence of emergency treatment from the hospital and/or treating physician. If the hospital or treating physician wants to know what information is needed, refer the hospital's staff or physician (or physician's staff) to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

The worker must send the medical evidence to:

Division of Program Operations
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

for a determination of medical emergency and the duration of the emergency services certification period. Use the Emergency Medical Certification, form #032-03-628 (see Appendix 4 of this subchapter) as a cover letter.

Do **not** take action to approve or enroll an emergency services alien until you receive the completed Emergency Medical Certification form back from DMAS. If approved, DMAS will provide the certification for Medicaid payment for emergency services and coverage begin and end dates.

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

A. Policy

An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.

B. Application & Entitlement

1. Application Processing

The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.

2. Entitlement

If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.

3. Spenddown

Spenddown provisions apply to medically needy individuals who have excess income.

4. Notice

Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.

C. Enrollment Procedures

Once a full benefit alien is found eligible for Medicaid, he must be enrolled on the Medicaid computer (MMIS) using the following data:

1. Cty

In this field, Country of Origin, enter the code of the alien's country of origin.

2. CI

In this field, Citizenship code, enter the MMIS citizenship code that applies to the alien. Next to the MMIS code is the corresponding Alien Code from the Alien Code Chart in Appendix 3 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
I = grandfathered aliens only (Alien Chart codes X1, X2, X3, Y1, Y2, Y3)

3. Entry date

THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation witholding was granted.

4. App Dt

In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. Covered Dates Begin

In this field, coverage begin date, enter the date the alien's Medicaid entitlement begins.

6. Covered Dates End — Enter data in this field only if eligibility *is a* closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.

7. PD (*AC)* — Enter the code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

A. Policy — Unqualified aliens, and qualified aliens eligible for emergency services only *(see M220.500)*, are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

B. Entitlement-Enrollment Period — *If the applicant is found eligible and is certified for emergency services,* eligibility exists only for the period of coverage *certified by the LDSS* or DMAS staff on the Emergency Medical Certification form, # 032-03-628 (see Appendix 4 of this subchapter).

Once an eligibility period is established, additional requests for coverage of emergency services *within 6 months* will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.

An emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if he/she receives an emergency service and wants Medicaid coverage for that service.

C. Enrollment Procedures — Once an emergency services alien is found eligible for *coverage of emergency services,* he must be enrolled on the Medicaid computer using the following data:

1. Cty — In this field, Country of Origin, enter the code of the alien's country of origin.

2. CI — In this field, Citizenship code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through *V3*) *other than dialysis patient.*

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 3 to this subchapter.

NOTE: Visitors are not usually eligible for Medicaid because usually they do not meet the Medicaid Virginia state residency requirement.

3. Entry date	**THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation witholding was granted.
4. App Dt	In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
5. Covered Dates Begin	In this field, coverage begin date, enter the begin date of the emergency service(s).
6. Covered Dates End	In this field, coverage end date, enter the date the alien's emergency service(s) ends.
7. PD *(AC)*	Enter the code applicable to the alien's covered group.

D. Notices

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.

A Medicaid card will not be generated for an enrolled emergency services alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628 Emergency Medical Certification to the provider(s).

A Medicaid card will not be generated for an enrolled *emergency services* alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628 Emergency Medical Certification to the provider(s).

***UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS)* OFFICES**

1. Agencies corresponding with *USCIS*, *2675 Prosperity Avenue, Fairfax, VA 22031* (phone: *1-800-375-5283*). These agencies use this *USCIS* address to reorder G-845 forms.

Albemarle
Alexandria
Alleghany
Amherst
Appomattox
Arlington
Bath
Bedford
Bland
Botetourt
Bristol
Buchanan
Buckingham
Campbell
Carroll
Charlotte
Charlottesville
Chesterfield
Clarke
Craig
Culpeper
Cumberland
Danville
Dickenson
Fairfax
Fauquier
Floyd
Fluvanna
Franklin County
Frederick
Galax
Giles
Grayson
Greene
Halifax
Harrisonburg
Henry
Highland
King George
Lee
Loudoun
Lynchburg
Madison
Manassas
Manassas Park
Martinsville
Montgomery
Nelson
Northumberland
Norton
Orange
Page
Patrick
Pittsylvania
Prince William
Pulaski
Radford
Rappahannock
Roanoke City
Roanoke County
Rockbridge
Rockingham
Russell
Scott
Shenandoah
Smyth
Stafford
Staunton
Tazewell
Warren
Washington
Waynesboro
Winchester
Wise
Wythe

2. Agencies corresponding with INS, Norfolk Commerce Park, 5280 Henneman Drive, Norfolk, VA 23513 (phone: *1-800-375-5283*). These agencies use this *USCIS* address to reorder G-845 forms.

Accomack
Amelia
Brunswick
Caroline
Charles City
Chesapeake
Dinwiddie
Essex
Franklin City
Fredericksburg
Gloucester
Goochland
Greensville
Hampton
Hanover
Henrico
Hopewell
Isle of Wight
James City
King and Queen
King William
Lancaster
Louisa
Lunenburg
Mathews
Mecklenburg
Middlesex
New Kent
Newport News
Norfolk
Northampton
Nottoway
Petersburg
Portsmouth
Powhatan
Prince Edward
Prince George
Richmond City
Richmond County
Southampton
Spotsylvania
Suffolk
Surry
Sussex
Virginia Beach
Westmoreland
Williamsburg
York

U.S. Department of Justice
Immigration and Natural Service

SAVE

OMB 1115-0122
Document Verification Request

Section A – to be completed by the submitting agency.

To: Immigration and Naturalization Service

From: Typed or Stamped Name and Address of Submitting Agency

Attn: Status Verifier
(INS may use above address with a #20 window envelope.)

1. Alien Registration or I-94 Number

2. Applicant's Name (*Last, First, Middle)*

3. Nationality

4. Date of Birth (*Month/Day/Year)*

5. Social Security Number

6. ☐ Verification Number

7. ☐ Photocopy of Document Attached.
(If printed on both sides, attach a copy of the front and of the back.)
☐ Other Information Attached *(Specify documents).*

8. *(Benefit)*	*(Your Case Number)*
☐ AFDC	
☐ Education Grant/Loans/Workstudy	
☐ Food Stamp	
☐ Housing Assistance	
☐ Medicaid/Medical Assistance	
☐ Unemployment Insurance	
☐ Employment Authorization	
☐ Other *(specify)*	

9. Name of Submitting Official

10. Title of Submitting Official

11. Date

12. Telephone Number

Section B – to be completed by INS

INS RESPONSE: From the documents or information submitted and/or a review of our records we find that:

1. ☐ This document appears valid and relates to a **Lawful Permanent Resident alien** of the United States.
2. ☐ This document appears valid and relates to a **Conditional Resident alien** of the United States.
3. ☐ This document appears valid and relates to an alien **authorized employment** as indicated below:
   a. ☐ Full-Time
   b. ☐ Part-Time
   c. ☐ No Expiration (Indefinite)
   d. ☐ Expires on
   (specify Month/Day/Year, below)
   _____
4. ☐ This document appears valid and relates to an alien who has an application pending for
   (specify Month/Day/Year, below)
   _____
5. ☐ This document relates to an alien having been **granted asylum/refugee** status in the United States.
6. ☐ This document appears valid and relates to an alien **paroled** into the United States pursuant to Section 212 of the I&N Act.
7. ☐ This document appears valid and relates to an alien who is a **Cuban/Haitian entrant.**
8. ☐ This document appears valid and relates to an alien who is a **conditional entrant.**
9. ☐ This document appears valid and relates to an alien who is a **nonimmigrant.**
   (*specify type or class below)*
   _____
10. ☐ This document appears valid and relates to an alien **not authorized employment** in the United States.
11. ☐ Continue to process as legal alien. INS is searching indices for further information.
12. ☐ This document is **not valid** because it appears to be
    (*check all that apply):*
    a. ☐ Expired
    b. ☐ Altered
    c. ☐ Counterfeit

INS Stamp

Form G-845 (Rev. 06/06/89)Y

Please see reverse for additional comments

Comments

13. ☐ No determination can be made from the information submitted. Please obtain a copy of the **original** alien registration documentation and resubmit.
14. ☐ No determination can be made without seeing **both** sides of the document submitted (*please resubmit request*).
15. ☐ Copy of document is not readable (*please resubmit request*):

"PRUCOL"

For Purposes of Determining If Alien Is Permanently Residing Under Color of Law Only!

16. ☐ INS actively pursues the expulsion of an alien in this class/category.
17. ☐ INS **is not** actively pursuing the expulsion of an alien in this class/category, at this time.

18. ☐ Other

Instructions

- **Submit copies of both *front and back* of alien's original documentation.**

- **Make certain a *complete return address* has been entered in the "From" portion of the form.**

- The Alien Registration Number ("A" Number) is the letter "A" followed by a series of (7) or (8) digits. Also in this black may be recorded the number found on Form I-94. (Check the front and back of the I-94 document, and if the "A" Number appears, record that number when requesting information instead of the longer admission number as the "A" Number refers to the most integral record available.)

- If Form G-845 is submitted without copies of applicant's original documentation, it will be returned to the submitting agency without any action taken.

- Address this verification to the local office of the Immigration and Naturalization Service.

*U.S. Government Printing Office: 1991 - 301-478/49236

Appendix 2: Document Verification Request Form (G-845)

The Document Verification Request (G-845) should be completed as fully as possible by the submitting agency. It is essential that the form contain enough information to identify the alien.

1.	**Alien Registration Number or I-94 Number**	Enter the Alien Registration Number as the letter "A" followed by a series of seven or eight digits. Include also the Admission Number if available. The Admission Number is found on Form I-94 and in the Alternate ID field located on the primary SAVE verification (automated process). The Admission Number may assist in the various searches made during secondary verification.
2.	**Applicant's Name**	Enter last, first, and middle names of the applicant. If documentation indicates more than one variation of the name, enter all versions.
3.	**Nationality**	Enter the foreign nation or country to which the applicant owes legal allegiance. This is normally, but not always, the country of birth.
4.	**Date of Birth**	Enter the birth date using the format MM/DD/YY. If the complete date of birth is not known, give available information.
5.	**Social Security Number**	Enter the alien's nine-digit Social Security Number, if known. Copy the number directly from the alien's Social Security card whenever possible .
6.	**Verification Number**	Enter the Verification Number assigned on the primary verification document, if applicable.
7.	**Photocopy of Document Attached/ Other Information Attached**	Indicate that INS documentation is attached by checking the top box. Use the bottom box if other information has been included in support or in lieu of INS documents .
8.	**Benefits Your Case Number**	Mark the blocks showing the entitlement benefit program(s) for which this alien has applied. Show applicable case numbers or indicate with "pending," if a case number has not yet been assigned.
9.	**Name and Address of Submitting Agency**	The submitting individual must provide his name, title, telephone number, and the current date. The name and address of the requesting agency should be typed or stamped in the block labeled "From." Copies of Form G-845 ordered from INS will include the address of the File Control Office responsible for processing the form.

U.S. Department of Justice
Immigration and Naturalization Service Document Verification Request Supplement

TO BE COMPLETED BY THE SUBMITTING AGENCY

To: Immigration and Naturalization Service Date_____

_____
Applicant's Name *(Last, First, Middle)*

_____
Social Security Number

_____
Alien Registration Number or I-94 Number

_____
FROM: Typed or Stamped Name and Address of Submitting Agency Telephone(____)_____

Complete the following items: #1 #2 #3 #4 #5 #6 #7
For SSA Use Only: Show 8/22/96 status in #1. Alleged 8/22/96 status _____

TO BE COMPLETED BY INS

1. IMMIGRATION STATUS (check all that apply):
From the document or information submitted and/or a review we find that the person identified is a/an:

a. Lawful Permanent Resident alien of the United States.
(Complete b, c, d, g, h, or I if alien adjusted to LPR status from one of those statuses in the past 7 years.)

b. Refugee admitted to the United States under Section 207 of the INA. (Complete Item 2 below.)

c. Asylee under Section 208 of the INA. (Complete Item 3 below.)

d. Alien whose deportation has been withheld under sections 243(b) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under section 241(b)(3).

e. Alien paroled into the United States under Section 212(d) (5) of the INA for a period of at least 1 year.
(compare Items 3 and 4 below.)

f. Conditional Entrant pursuant to Section 203(a)(7) of the INA in effect prior to April 1, 1980.

g. American Indian born in Canada to whom the provisions of Section 289 of the INA apply.

h. Cuban/Haitian Entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980.
(Compare Item 3 below)

i. Amerasian immigrant, pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1988. (Complete Item 2 below.)

j. Other (indicate status):_____

2. Date Alien entered the United States_____

3. Date status was granted:_____

4. Date status expires:_____

5. CITIZEN STATUS:
This document appears valid and relates to a United States citizen.

6. SPECIAL BENEFIT PROVISIONS FOR CERTAIN VICITMS OF ABUSE:

a. This alien obtained Lawful Permanent (or Conditional) Resident Status as the spouse, child, or widow(er) of a U.S. citizen.

b. This alien obtained a Lawful Permanent (or Conditional) Resident Status as the spouse, child, or unmarried son or daughter of a lawful permanent resident alien.

c. This alien did not obtain status as described in (a) or (b).

TO BE COMPLETED BY INS

7. AFFIDAVIT OF SUPPORT:

a. This alien was sponsored on Form I-864. Affidavit of Support under Section 213A of the INA.
Service receipt date_____(Complete Item 3 on page 1.)

b. This alien was not sponsored on Form I-864.

Name of Sponsor	Name of Joint Sponsor(s) (*if any*)
Sponsor's Social Security Number ___ ___ ___-___ __-___ ___ ___ ___	Joint Sponsor's Social Security Number ___ ___ ___-___ __-___ ___ ___ ___
Sponsor's Address	Joint Sponsor Address
	See reverse for information on additional joint sponsor(s).

INS Stamp

- *This supplement may be used in conjunction with Form G-845 to request verification; it cannot be used alone. It reflects information that may be relevant to eligibility for Federal, State, and local public benefits under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193.*

Line Item	MEDICAID ALIEN CODE CHART ***QUALIFIED ALIEN GROUPS***	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	Emergency Only C3
			1st 7 years	After 7 years
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Emergency Only D3
E	Aliens*, other than Cuban or Haitian Entrants,* paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)]	Full Benefit E1	Emergency Only E2	Emergency Only E3
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {*including those under section 212(d)(5)},* or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Emergency Only I3
J	Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter]	N/A J1	Full Benefit J2	Emergency Only J3

	UNQUALIFIED ALIEN GROUPS	Arrived Before 8-22-96	Arrived On or After 8-22-96	
K	Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter]	Emergency Only *K1*	Emergency Only *K2*	Emergency Only *K3*
L	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only *L1*	Emergency Only *L2*	Emergency Only *L3*
M	Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing [I-94; I-210]	Emergency Only *M1*	Emergency Only *M2*	Emergency Only *M3*
N	Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing [I-181; Endorsed Passport]	Emergency Only *N1*	Emergency Only *N2*	Emergency Only *N3*
O	Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing [I-94; Court Order; INS Letter]	Emergency Only *O1*	Emergency Only *O2*	Emergency Only *O3*
P	Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing [I-94; I-210; I-688B – 247a.12(a)(11) or (13)]	Emergency Only *P1*	Emergency Only *P2*	Emergency Only *P3*
Q	Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later [I-210; INS Letter]	Emergency Only *Q1*	Emergency Only *Q2*	Emergency Only *Q3*
R	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only *R1*	Emergency Only *R2*	Emergency Only *R3*
S	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only *S1*	Emergency Only *S2*	Emergency Only *S3*

	UNQUALIFIED ALIEN GROUPS (cont.)	Arrived Before 8-22-96	Arrived On or After 8-22-96	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only *T1*	Emergency Only *T2*	Emergency Only *T3*
U	Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing [INS Contact]	Emergency Only *U1*	Emergency Only *U2*	Emergency Only *U3*
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only *V1*	Emergency Only *V2*	Emergency Only *V3*
W	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A]	Emergency Only *W1*	Emergency Only *W2*	Emergency Only *W3*
	GRANDFATHERED ALIEN GROUPS			
X	Unqualified aliens or emergency services qualified aliens who • were eligible for and receiving Medicaid LTC services in medical facilities or CBC waivers on 6-30-97, and • who continue to reside in LTC medical facilities or continue to receive CBC Medicaid CBC waiver services	Full Benefits *X1*	Full Benefits *X2*	Full Benefits *X3*
Y	Unqualified aliens or emergency services qualified aliens under age 19 years who meet the alien status requirements that were in effect before 7-1-97	Full Benefits *Y1*	Full Benefits *Y2*	Full Benefits *Y3*

Commonwealth of Virginia
Department of Social Services

APPLICANT'S NAME:

_____

CASE NUMBER:

EMERGENCY MEDICAL CERTIFICATION

TO: DIVISION OF PROGRAM OPERATIONS
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

I. REFERRAL SECTION

THE ABOVE-NAMED INDIVIDUAL HAS APPLIED FOR MEDICAID. A DETERMINATION OF EMERGENCY NEED AND DURATION IS NEEDED NO LATER THAN _____.
(DATE)

INDIVIDUAL'S STATUS: ☐ A ☐ B ☐ C
ATTACHED IS INFORMATION ON THE EMERGENCY MEDICAL TREATMENT.

SIGNED: _____ WORKER #: _____ DATE: _____

AGENCY
NAME:_____

AGENCY
ADDRESS:_____

II. CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINED THAT THE MEDICAL CONDITION
☐ IS AN EMERGENCY ☐ IS NOT AN EMERGENCY

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED:_____ TITLE: _____ DATE: _____

III. NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

☐ THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID BENEFITS.

REASON FOR DENIAL:_____

☐ THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627.

PERIOD OF COVERAGE: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

SIGNED: _____TITLE: _____DATE:_____

Appendix 4: EMERGENCY MEDICAL CERTIFICATION

FORM NUMBER - 032-03-628

PURPOSE

1. To request from the Department of Medical Assistance Services (DMAS) certification that the medical service received by an emergency services alien was an emergency.

2. To certify that the medical service was an emergency as defined by law and to provide the reason(s) for the decision and the duration of the emergency coverage.

3. To notify the medical service provider(s) that the emergency services alien is either ineligible or eligible for Medicaid, and for what coverage period, in lieu of generating a Medicaid card.

USE OF FORM - Completed for all emergency services alien applicants.

NUMBER AND DISTRIBUTION OF COPIES - Prepare original; make copy for agency record before sending original to DMAS. DMAS will complete Section II and return the "Local Agency" and "Emergency Service Provider" copies to the agency. After completing Section III, the agency will keep the "Local Agency" copy of the original in the eligibility case folder and send the "Emergency Service Provider" copy to the provider(s).

Forms must be retained for a period of three years following the current fiscal year if a federal audit has been made within that period and no audit questions have been raised. If such an audit has not been made within that time, the form must be retained until an audit has been made or until the end of five years following the current fiscal year, whichever is earlier. In all cases, if audit questions are raised, the form must be retained until the questions are resolved.

INSTRUCTIONS FOR PREPARATION OF FORM

SECTION I - REFERRAL SECTION -Enter the date which is 45 days or 90 days if applicant is applying as disabled) from the application date in the blank marked "(Date)". Check the individual's status; "A" for the Qualified Alien, "B" for the Unqualified Aliens and "C" for the Undocumented Alien. The worker must sign his/her own name and complete the worker number, the date the section was completed and the agency name and address.

SECTION II - CERTIFICATION SECTION - The authorized DMAS staff person completes this section, signs his/her name, title and the date, keeps the carbon copy marked "DMAS", and sends the original and provider copy back to the agency.

SECTION III - NOTIFICATION SECTION - The worker checks the appropriate box. If the applicant is ineligible, briefly state why. If the applicant is eligible, note the begin and end dates of coverage and the recipient's Medicaid I.D. number, and other health insurance. The worker must sign his/her own name, title and the date this section was completed, which should also be the date this notice is sent to the emergency service provider. Send the carbon copy marked "Emergency Service Provider" to the provider(s) of emergency services received within the coverage period. This notice serves in place of a Medicaid card as verification of the applicant's Medicaid coverage. A separate "Notice of Action on Medicaid" form #032-03-008 is sent to the applicant and no Medicaid card is generated.

Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking

[Used For Adults]

HHS Tracking Number

(Address)

CERTIFICATION LETTER

Dear _____:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000. Your certification date is _____. Certification does not confer immigration status.

With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking

[Used For Children Under Age 18 Years]

HHS Tracking Number

(Address)

Dear _____:

This letter confirms that pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

Your initial eligibility date is _____. This letter does not confer immigration status.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents

This appendix contains the process for determining the number of qualifying quarters (QQ) with which a lawful permanent resident (LPR) who entered the U.S. on or after 8-22-96 can be credited and is to be used in conjunction with the State Verification Exchange System (SVES) User Guide.

I. Procedures:

A. To determine the number of QQ available to a LPR applicant, ask the applicant the following questions:

1. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) lived in this country?

2. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) commuted to work in the U.S. from another country before coming to the U.S. to live, or worked abroad for a U.S. company, or worked in self-employment while a legal resident of the U.S.?

   (If the total number of years to both questions is less than 10 years, **STOP** because the applicant cannot meet the 40 QQ requirement.)

3. In how many of the years reported in the answer to question 1 did the applicant, the applicant's spouse, or the applicant's parent earn money through work?

B. To determine whether the applicant's earnings were sufficient to establish "quarters of coverage" in those years, refer to the income chart in section II .

   If the answer to question 3 is 10 years or more, verify from INS documents or other documents the date of entry into the country for the applicant, spouse and/or parent. If the dates are consistent with having 10 or more years of work, initiate a SVES inquiry.

C. Complete or obtain from the applicant a completed "Consent for Release of Information" (see page 4 of this appendix) with the full name, social security number and date of birth of each individual (self, spouse, or parent) whose work history is relevant. In addition, the applicant must provide a form signed by each such individual, except deceased persons, giving SSA permission to release information through SVES on that individual to the agency and/or the applicant. Retain the consent form in the case file to document the individual's consent. A consent form is valid for 12 months from the time of the signature.

D. Information received through SVES will not report earnings for the current year nor possibly the last year's earnings (i.e. the lag period). The SVES report will also not include employment that is not covered under Social Security (i.e. not requiring payment of FICA/Social Security tax). The applicant must provide verification of earnings through pay stubs, W-2 forms, tax records, employer records, or other documents, if quarters of the lag period or non-covered employment are needed to meet the 40-quarter minimum. Use the information contained in section II to determine QQ for lag periods and non-covered earnings.

If the alien believes the information from SSA is inaccurate or incomplete, beyond the current two-year lag period, advise the applicant to provide the verification to SSA to correct the inaccurate income records.

In evaluating the verification received directly from the applicant or through SVES, **exclude** any quarter, beginning January 1997, in which the person who earned the quarter received benefits from TANF, SSI, or Medicaid, or Food Stamp Programs or the food assistance block grant program in Puerto Rico.

E. In situations when consent to release information through SVES cannot be obtained from a parent or spouse, other than death, request information about quarters of coverage directly from the Social Security Administration. Complete or obtain from the applicant a Request for Quarters of Coverage (QC) History Based on Relation form, SSA-513. The form specify the period(s) for which the verification is requested. Submit the completed from to:

Social Security Administration
P.O. Box 33015
Baltimore, Maryland 21290-3015

F. When the SSA is unable to determine if a quarter should be allowed, the SVES inquiry will show "Z" or "#" codes. If an applicant cannot meet the 40-quarter minimum without using a questionable quarter, SSA will investigate the questionable quarter(s) and will either confirm or deny the quarter. Use Form SSA-512, "Request to Resolve Questionable Quarters of Coverage (QC)," to resolve quarters before 1978. A copy of the SVES report must accompany the completed form. Submit Form SSA-512 to:

Social Security Administration
Office of Central Records Operations
P.O. Box 33015
Baltimore, Maryland 21290-3015

For questionable quarters for 1978 or later, the applicant must complete Form SSA-7008. "Request for Correction of Earnings." This form is available at local SSA offices. At the top of the form write "Welfare Reform." Submit the form and proof of earnings to:

Social Security Administration
Office of Central Records Operations
P.O. Box 30016
Baltimore, Maryland 21290-3016

II. Establishing Quarters:

Use the following information to (1) determine whether the applicant's earnings as reported in section I.A were sufficient to establish quarters of coverage and (2) to determine the number of QQ during lag periods and when the reported employment is not a covered earning for Social Security reporting purposes:

- A quarter is a period of 3 calendar months ending with March 31, June 30, September 30 and December 31 of any year.

- Social Security quarters of coverage are credits earned by working at a job or as a self-employed individual. A maximum of four credits or quarters can be earned each year.

- For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of creditable QQ are obtained by dividing the total earned income by the increment amount for the year. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The amount of earnings needed for each credit and the amount needed for a year in order to receive four credits are listed below.

Year	Quarter Minimum	Annual Minimum	Year	Quarter Minimum	Annual Minimum
1978	$250	$1000	1991	$540	$2160
1979	$260	$1040	1992	$570	$2280
1980	$290	$1160	1993	$590	$2360
1981	$310	$1240	1994	$620	$2480
1982	$340	$1360	1995	$630	$2520
1983	$370	$1480	1996	$640	$2560
1984	$390	$1560	1997	$670	$2680
1985	$410	$1640	1998	$700	$2800
1986	$440	$1760	1999	$740	$2960
1987	$460	$1840	2000	$780	$3120
1988	$470	$1880	2001	$830	$3320
1989	$500	$2000	2002	$870	$3480
1990	$520	$2080	2003	$890	$3560

- A current year quarter may be included in the 40-quarter computation. Use the current year amount as the divisor to determine the number of quarters available.

If you need to use quarters before 1978:

- A credit was earned for each calendar quarter in which an individual was paid $50 or more in wages (including agricultural wages for 1951-1955);

- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were $400 or more; and/or

- A credit was earned for each $100 (limited to a total of 4) of agricultural wages paid during the year for years 1955-1977.

Social Security Administration OMB No. 0960-0567

Consent for Release of Information
TO: Social Security Administration

_____	_____	_____
Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

I want this information released because:

_____
_____
_____
_____
(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _____ to _____
_____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
_____ Medical records
_____ Record(s) from my file (specify) _____
_____
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

SSA-3288

OMB NO: 0960-0575

Date of Request_____

REQUEST TO RESOLVE QUESTIONABLE QUARTERS OF COVERAGE (QC)

Complete the information below when the QC array contains either a (#) pound sign or code "Z" prior to 1978. Mail the form and a copy of the system's printout to the Social Security Administration, PO Box 17750, Baltimore, MD. 21235-0001.

Print
Name: _____ _____ _____
Last First MI

SSN_____-_____-_____ Date of Birth _____-_____-_____
MM DD YY

Request Years

19_____, 19_____, 19_____, 19_____, 19_____, 19_____,

19_____, 19_____, 19_____, 19_____, 19_____, 19_____,

20_____, 20_____, 20_____.

OR

19_____ thru 19_____, 19_____ thru 19_____, 19_____, thru 19_____,

20_____ thru 20_____.

State's Name & Address _____

_____

_____

Contact Person's Name _____
&
Telephone Number _____

The *Paperwork Reduction Act of 1995* requires us to notify that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

SSA-512

Date of Request _________ QMB NO: 0960-0575

REQUEST FOR QUARTERS OF COVERAGE (QC) HISTORY BASED ON RELATIONSHIP

Complete the information below when requesting QC history for spouse(s) or parent (s) of a lawfully admitted non-citizen applicant. Mail the form to the Social Security Administration, PO Box 17750, Baltimore, MD 21235-0001.

Print Name: __________________________ __________________________ __________
Last First MI

SSN ________-________-________ Date of Birth ______-______-______
MM DD YY

Relationship to Applicant ___________________________________

NOTE: COMPLETE THE YEAR COLUMN AND CIRCLE THE PERTINENT QUARTER (S) FOR THE YEAR. SSA WILL PROVIDE INFORMATION ONLY FOR YEARS AND QUARTERS YOU INDICATE.

		QC PATTERN					QC PATTERN		
YEAR	1ST Q	2nd Q	3RD Q	4TH Q	YEAR	1ST Q	2nd Q	3RD Q	4TH Q
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

State's Name & Address ____
____
____

Contact Person's Name & Telephone Number ____
____

FORM SSA-513 (9/97)

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 30

VIRGINIA RESIDENCY REQUIREMENTS

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

	Section	Page
Policy Principles	M0230.001	1
Definition of Terms	M0230.100	1
Residency Requirements	M0230.200	2
Individuals Under Age 21	M0230.201	2
Individuals Age 21 and Older	M0230.202	3
State Placement In Institution	M0230.203	4
Cash Assistance Program Recipients	M0230.204	6
Specific Prohibitions	M0230.300	6
Disputed Residency	M0230.400	7

M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

M0230.001 POLICY PRINCIPLES

A. Policy

An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.

An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).

For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).

B. Retention of Residency

Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.

C. Cross-Reference to Intra-State Transfer

Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.

M0230.100 DEFINITION OF TERMS

A. Introduction

For purposes of this subchapter only, the terms in this section have the following meanings:

B. Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

For purposes of state placement of an individual, the term "institution" also includes foster care homes approved by the state and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

C. In An Institution

"In an institution" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

D. Incapable of Indicating Intent

An individual is incapable of declaring his intent to reside in Virginia or any state if the individual:

- has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Virginia Department of Mental Health

Mental Retardation & Substance Abuse Services (DMHMRSAS);

- is judged legally incompetent; or
- is found incapable of declaring intent to reside in a specific state based on medical documentation obtained from a physician, psychologist, or other professional licensed by the State in the field of mental retardation.

E. Virginia Government Agency

A Virginia government agency is any state or local government agency, and any entity recognized by State law as being under contract with a Virginia state or local government agency.

M0230.200 RESIDENCY REQUIREMENTS

M0230.201 INDIVIDUALS UNDER AGE 21

A. Under Age 21 NOT In An Institution

1. Blind or Disabled

For any individual under age 21

- who is not residing in an institution (as defined above in M0230.100) AND
- whose Medicaid eligibility is based on blindness or disability

the state of residence is the state in which the individual is living. If the individual lives in Virginia, he/she is a Virginia resident.

2. Other Individuals Under Age 21

An individual under age 21 who is **not** in an institution is considered a resident of Virginia if he/she:

a. is married or emancipated from his/her parents, is capable of indicating intent and is residing in Virginia with the intent to remain in Virginia permanently or for an indefinite period;

b. is presently living in Virginia on other than a temporary basis;

c. lives with a caretaker who entered Virginia as a result of a job commitment or a job search (whether or not currently employed) and is not receiving assistance from another state;

d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);

e. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);

f. is a *non-IV-E* foster care child whose custody is held by a licensed, private foster care agency in Virginia, *regardless of the state in which the child physically resides*;

g. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, or visit) but is still in the custody of his/her parent(s) who reside in Virginia.

B. Under Age 21 In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or

3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the party who files the Medicaid application resides in Virginia.

4. for an individual under 21, if a legal guardian has been appointed for the child and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

M0230.202 INDIVIDUALS AGE 21 OR OLDER

A. Introduction

For an individual age 21 or older, the determination of state residency depends on

- whether or not the individual is in an institution, and
- whether or not the individual is capable of indicating his or her intent to reside in the state.

B. Age 21 Or Older NOT In An Institution

For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:

- the individual is living in Virginia with the intention to remain in Virginia permanently or for an indefinite period;
- the individual is incapable of indicating intent and the individual is living in Virginia; or

- the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).

C. Age 21 Or Older In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

1. Capable of Stating Intent

An individual in an institution who is age 21 or over and who is capable of declaring his intent to reside in Virginia, is a resident of Virginia if the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period.

2. Became Incapable Before Age 21

An individual in an institution who is age 21 or over and who became incapable of stating intent before age 21 is a Virginia resident if:

a. regardless of the physical location where the individual actually resides, Virginia is the individual's state of residence when the individual's legal guardian or parent who files the Medicaid application resides in Virginia;

b. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

c. the individual's parent or legal guardian who applies for Medicaid resides in Virginia and the individual is institutionalized in Virginia; or

d. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia and the party who files the Medicaid application resides in Virginia.

If a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

3. Became Incapable At or After Age 21

An individual in an institution who is age 21 or over and who became incapable of stating intent at or after age 21 is a Virginia resident if he or she is residing in Virginia and was not placed here by another state.

M0230.203 STATE PLACEMENT IN INSTITUTION

A. Policy

Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state, is recognized as acting on behalf of the state in making the placement. The

state arranging or actually making the placement is considered the individual's state of residence. When an individual is placed by state or local government in an institution in another state, the individual remains the responsibility of the placing state unless the state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility.

When an individual is placed by a Virginia government agency in an institution in another state, the individual remains the responsibility of Virginia unless

- a state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility,
- *the individual is a child who receives a IV-E foster care or adoption assistance payment, or*
- *the individual is a child who receives **non-IV-E adoption assistance** and the state in which he is placed is a reciprocal state under the interstate compact, verified by the central office Deputy Compact Administrator, Adoption Unit, Division of Family Services, Department of Social Services (DSS).*

B. State Placement

Placement by a state government agency is any action taken by the agency, beyond providing general information to the individual and the individual's family, to arrange admission to an institution for the individual. The following actions do not constitute state placement:

- providing basic information to individuals about other states' Medicaid programs or about the availability of health care services and facilities in other states;
- assisting an individual, who is capable of declaring intent and who independently decides to move out-of-state, in locating an institution in another state.

1. Lack Of Facilities

Where a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.

2. Individual Leaves Facility

When a competent individual leaves the facility in which the individual was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

C. Individual Placed Out-of-State by Virginia Government

An individual can leave Virginia and retain Virginia residency if he/she is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical

Assistance Services in order for Virginia Medicaid to pay for the institutional care.

When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.

M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

A. Introduction

Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. *Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.*

B. Auxiliary Grants Recipients

An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.

An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.

C. IV-E Payment Recipients

For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.

An individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act from a Virginia locality is considered a resident of the state where the individual resides for Medicaid purposes. An individual who lives in Virginia and receives federal IV-E foster care or adoption assistance payments from another state is considered a Virginia resident for Medicaid eligibility purposes. Conversely, an individual who lives in another state but receives a IV-E foster care or adoption assistance payment from Virginia is considered a resident of that other state for Medicaid eligibility purposes.

D. Non-IV-E *Foster Care* Recipients

The non IV-E (state/local) foster care payment recipient is a resident of the state that is making the non IV-E payment. An individual who receives non IV-E foster care payments from Virginia is considered a Virginia resident for Medicaid eligibility purposes, regardless of the state in which he/she actually resides. Conversely, an individual who lives in Virginia but receives a non IV-E foster care payment from another state is considered a resident of that other state for Medicaid eligibility purposes.

E. Non-IV-E Adoption Assistance Recipients

The non IV-E (state/local) adoption assistance child is a resident of Virginia when the child receives non-IV-E adoption assistance from a Virginia locality. If the Virginia non-IV-E adoption assistance child

moves or is placed outside Virginia, the child becomes a resident of the state to which he/she moves IF that state meets the reciprocity requirements under the interstate compact for adoption assistance. Verify whether the state is a reciprocal state by contacting the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Department of Social Services (DSS).

A child who receives non IV-E adoption assistance from another state but who lives in Virginia is considered a Virginia resident for Medicaid eligibility purposes IF that state meets the reciprocity requirements under the interstate compact for adoption assistance. Verify whether the state is a reciprocal state by contacting the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Department of Social Services (DSS).

M0230.300 SPECIFIC PROHIBITIONS

A. No Fixed Address

The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.

For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he/she must come to the social services department to receive his/her card until he/she obtains a fixed address.

B. Length of Residency

The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.

C. Residency in Virginia Prior to Admission to Institution

The agency may not deny Medicaid eligibility to an individual in an institution who meets the Virginia residency requirements previously identified in this subchapter, because the individual did not establish residence in Virginia before entering the institution.

D. Temporary Absence

The agency may not deny or terminate Medicaid eligibility because of that individual's temporary absence from Virginia if the individual intends to return to Virginia when the purpose of the absence has been accomplished, UNLESS another state has determined that the individual is a resident there for Medicaid purposes.

M0230.400 DISPUTED RESIDENCY

A. Disputed or Un-clear Residency

If state residency is unclear or is in dispute, contact the regional specialist for help in resolution. When two or more states cannot resolve the residency, the state where the individual is physically located becomes the state of residence.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 40

SOCIAL SECURITY NUMBER REQUIREMENTS

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

	Section	Page
General Principle	M0240.001	1
Application For SSN	M0240.100	1

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLE

A. Policy

To be eligible for Medicaid, an individual must provide his/her Social Security account number (SSN) as well as the Social Security account numbers of any children for whom Medicaid is requested, or must provide proof of application for a Social Security account number, UNLESS the applicant

- is an illegal alien as defined in subchapter M0220, or
- is a child under age 1 as defined in *M0320.301 B. 2*.

B. Failure to Meet This Requirement

Any Medicaid family unit member for whom an application for a Social Security number has not been filed or for whom the SSN is not furnished **is not eligible** for Medicaid EXCEPT for:

1. a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.

2. an illegal alien as defined in Section M0220; an illegal alien does not have to provide or apply for a social security number.

C. Verification

The individual's Social Security number is verified by the IEVS system when the individual is entered in that system.

D. Procedure

Section M0240.100 below explains in detail how to determine if an individual meets the Social Security number requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

A. Policy

If a Social Security account number has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office.

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that a Social Security number be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application.

Proof of application for a Social Security number from the Social Security office, or form SSA-2853 must be provided to the local social services agency by the applicant/recipient.

B. Failure to Meet This Requirement

Any Medicaid family unit member for whom a Social Security number has not been applied **is not eligible** for Medicaid EXCEPT for:

1. a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.

2. an illegal alien as defined in Section M0220; an illegal alien does not have to provide or apply for a social security number.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 50

ASSIGNMENT OF RIGHTS *AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS*

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0250.000 ASSIGNMENT OF RIGHTS *AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT* REQUIREMENTS

	Section	Page
General Principles	M0250.001	1
Condition of Eligibility	M0250.100	1
Procedures for Assignment of Rights	M0250.200	2
Pursuit of Support From the Absent Parent	*M0250.300*	*3*
Determining Parent's Absence	*M0250.400*	*4*
Support From the Absent Parent	*M0250.500*	*5*

Appendix

Notice of Cooperation and Good Cause	*Appendix 1*	*1*
Good Cause Determination	*Appendix 2*	*1*
Absent Parent/Paternity Information	*Appendix 3*	*1*
Medicaid Information Transmittal	*Appendix 4*	*1*

M0250.000 ASSIGNMENT OF RIGHTS *AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT* REQUIREMENTS

M0250.001 GENERAL PRINCIPLES

A. Introduction

The assignment of rights to medical support and the pursuit of support from absent parent(s) are Medicaid nonfinancial requirements that must be met as a condition of Medicaid eligibility.

B. Policy and Procedures

The policy and procedures for the local agency to follow in determining if an individual has met the Medicaid assignment of rights and pursuit of support from absent legally responsible relatives are contained in the following sections:

- M0250.100 Assignment of Rights
- M0250.200 Procedures for the Assignment of Rights
- M0250.300 Pursuit of Support From the Absent Parent
- M0250.400 Determining the Parent's Absence
- M0250.500 Support From the Absent Parent

M0250.100 CONDITION OF ELIGIBILITY

A. Policy

To be eligible for Medicaid, a Medicaid applicant or recipient must:

- assign his rights to medical support and payment for medical care from any third party to the Department of Medical Assistance Services (DMAS);
- assign the rights of any other individual for whom he applies and can make an assignment of rights to support and third party payments;
- cooperate with the agency in identifying (to the extent he/she is able) potentially liable insurers and other third parties and providing information to assist DMAS in pursuing payments from any third party who may be liable to pay for the individual's, and any other individual for whom he can assign rights, care and medical services, unless the individual has good cause for refusing to cooperate.

B. Individual Unable To Assign Rights

If the individual is unable to his assign rights, a spouse, legally appointed guardian or conservator, attorney-in-fact (person who has the

individual's power-of-attorney), or the authorized representative can make such an assignment. If the individual is a child, the parent, legal custodian, authorized representative, or the adult relative with whom the child lives and who signed the application can assign rights.

If the person who has the authority to assign the applicant's/recipient's rights refuses to assign the rights, the person who has the authority to assign the rights will be ineligible for Medicaid. However, the applicant/recipient will meet the assignment of rights requirement and can be eligible for Medicaid if he meets all other eligibility requirements.

M0250.200 PROCEDURES FOR ASSIGNMENT OF RIGHTS

A. Forms

The assignment of rights information is contained on the following application forms used for Medicaid:

- Application For Benefits (form #032-03-824),
- Application/Redetermination For Medical Assistance For SSI Recipients (form #032-03-091),
- *An Application for Children's Health Insurance in Virginia (form FAMIS – 1),*
- Medicaid Application For Medically Indigent Pregnant Women (form #032-03-040), and
- *the ADAPT Statement of Facts.*

By signing the application for Medicaid, the individual assigns his/her own rights and the rights of anyone for whom the individual has applied and can assign rights.

B. Refusal To Assign Rights Or Cooperate

An individual who is able to assign rights but who refuses or fails to meet the assignment of rights requirements in this subchapter is not eligible for Medicaid. Deny or cancel Medicaid coverage to an individual who:

- refuses to assign his own rights or those of any other applicant for whom he can make an assignment,
- refuses to cooperate in identifying and providing liable third party information, unless cooperation has been waived for good cause.

C. Cooperation

Cooperation in assisting the agency in securing medical support and payments includes requiring the individual to:

- provide identifying information about liable third parties, such as the liable person's insurance company and policy number, the medical services covered by the insurance policy, etc.;
- appear as a witness at a court or other proceeding;
- provide information, or attest to lack of information, under penalty of perjury;
- pay to the agency any medical care funds received that are covered by the assignment of rights; and
- take any other reasonable steps to assist the state in pursuing any liable third party.

1. Waiver of Cooperation

A waiver of the cooperation requirement in identifying and providing liable third party information is allowed if the agency finds that cooperation is against the best interests of the individual, or other person for whom he/she can assign rights, because the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.

2. Documentation

Document the case record with the reason(s) the individual refuses to cooperate in identifying and providing liable third party information and the reason(s) the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can assign rights.

M0250.300 PURSUIT OF SUPPORT FROM THE ABSENT PARENT

A. Policy

To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in:

- obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating;
- establishing paternity of, and in obtaining medical support and payments from the absent parent of a child, unless the individual applicant is a medically indigent (MI) pregnant woman applying for herself and her child born out of wedlock, the individual establishes good cause for not cooperating, or the individual is only eligible under the family planning services covered group.

B. Definition of Cooperation

To meet the cooperation requirements, the individual must:

- appear at a local department of social services office, a Division of Child Support Enforcement (DCSE) office, a Medicaid office, court or other hearing or proceeding as requested;

- provide verbal or written information as requested, or state under penalty of perjury that he/she has no knowledge of the information requested;
- help identify or locate the parent of a child for whom Medicaid is requested;
- help establish paternity of a child born out of wedlock for whom Medicaid is requested; and
- help obtain child support, medical support or any other money or property owed to the applicant/recipient or child receiving Medicaid. This includes insurance companies who may be liable to pay for the applicant/recipient's or child's medical services.

Determine if the individual meets the Medicaid definition of cooperation before taking action on the individual's Medicaid application or coverage. For example, if the individual cannot give the first and last name of the child's father, she must be allowed to sign a statement under penalty of perjury that she does not know the name of the father. If she signs such a statement, she meets the Medicaid definition of cooperation.

M0250.400 DETERMINING PARENT'S ABSENCE

A. Introduction

The income and resources of a parent who lives with his or her child under age 21 are considered available to the child. After the month in which the child ceases to live with a parent, only the income and resources which the parent actually makes available to the child are counted. This applies even if the child returns to the parent's household for periodic visits.

This section contains policy and procedure for determining when a parent is absent from the child's home.

B. ABD Covered Groups

A blind/disabled child under age 21 who is **temporarily** living away from his/her parent's home is considered living with the parent and the parent's income and resources must be deemed available to the child when determining the child's eligibility. The deeming policy in subchapter M0530 applies.

When the child is indefinitely away from his/her parent's home or has been screened and approved for LTC services, the eligibility of the child is determined on the basis of the actual contribution made by an absent parent.

C. F&C Covered Groups

A child who is **temporarily** living away from his/her parent's home is considered living with the parent and the family unit policy in subchapter M0520 applies.

If the child is living apart from the parent or is receiving LTC services, only the income and resources which the parent actually makes available to the child are counted.

M0250.500 SUPPORT FROM ABSENT PARENT

A. Policy

A parent/caretaker who is applying for Medicaid for himself and on behalf of a child *under age 18* (*DCSE will not pursue medical support for children age 18 and over unless a court order has extended support beyond age 18)* who has an absent parent must *cooperate* with the agency and DCSE in establishing the paternity and in obtaining medical support for the Medicaid eligible child, unless the:

- parent/caretaker is an MI pregnant woman and is requesting assistance for herself and her child born out of wedlock, or
- the parent/caretaker has good cause for not cooperating, or
- the parent/caretaker is only eligible under the Family Planning Services (FPS) covered group.

Explain and offer DCSE services to **all** Medicaid applicants, who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child's parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

If the parent/caretaker is required to cooperate with the agency in the pursuit of support from an absent parent as a condition of eligibility and refuses or fails to cooperate, he/she is ineligible for Medicaid. The parent's refusal or failure to cooperate does not affect the child's eligibility for Medicaid.

B. DCSE

DCSE District Offices were established in all regions and have the responsibility of pursuing support from absent legally responsible parent(s) and establishing paternity when the alleged father is absent from the home. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child (ren), and court action to secure support from the absent legally responsible parent. The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.

C. Cooperation with DCSE

Medicaid recipients (except an MI pregnant woman under certain conditions in D. below, child-only cases in G. below, and FPS woman in H. below) are required to cooperate with paternity establishment and securing medical support as a condition of eligibility for Medicaid. Cooperation in the establishment or enforcement of a child support obligation is optional and Medicaid recipients may refuse these services not related to medical support or paternity establishment.

D. Exception For MI Pregnant Women

An MI pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.

E. No Exception For MN Pregnant Women

If a pregnant woman has countable income over the MI limit, she may be eligible for medically needy (MN) Medicaid if her resources are within the MN limit, she meets a spenddown and she meets all nonfinancial requirements including cooperation in pursuing support. An MN pregnant woman must cooperate with the agency in obtaining medical support for herself and any child for whom she applies from a legally responsible relative, unless she has good cause for not cooperating.

F. Child Born to Medicaid Eligible Pregnant Woman

When a child is born to a Medicaid eligible woman and is enrolled in Medicaid, contact the parent with whom the child lives as soon as administratively possible, but no later than 60 days after the child's birth to explain and offer DCSE services.

A child born to a Medicaid eligible pregnant woman remains eligible for Medicaid even when the parent/caretaker refuses to cooperate with DCSE in establishing paternity and pursuing support. The parent/caretaker's refusal to cooperate with DCSE results in the parent/caretaker's ineligibility for Medicaid, regardless of the covered group, but does not impact the child.

G. Child-Only Cases

In child-only cases, cooperation with DCSE in the establishment of paternity and the pursuit of support is not a condition of the child's eligibility. DCSE services are available to all Medicaid recipients, but the parent/caretaker's refusal or failure to cooperate with DCSE will not affect the child's Medicaid eligibility.

H. Family Planning Services (FPS) Covered Group

For the FPS covered group, cooperation with DCSE in the establishment of paternity and pursuit of support is not a condition of eligibility. The woman's refusal or failure to cooperate with DCSE does not affect her eligibility in this covered group (see M320.302).

I. Procedures For Pursuing Support

The procedures for pursing support from absent parents are different depending on whether or not the parent/caretaker is also a Medicaid applicant/recipient.

1. Parent/ Caretaker is a Medicaid Applicant/ Recipient

When the parent/caretaker is also applying for Medicaid and cooperation with DCSE is a condition of the eligibility, the cooperation requirements must be met or good cause for not cooperating must be established prior to approval. A parent/caretaker who does not meet the cooperation requirements and does not establish good cause for not meeting the cooperation requirements is not eligible for Medicaid.

The following forms are used to determine if the cooperation requirements are met.

a. "The Notice of Cooperation and Good Cause", form #032-03-036 (see M0250, Appendix 1)

The "Notice of Cooperation and Good Cause" form is used to inform all parent/caretakers who apply for Medicaid for children who have an absent parent of the benefits of cooperation, claiming good cause for not cooperating, the good cause determination, and penalty for refusing or failing to meet cooperation requirements. The "Notice of Cooperation and Good Cause" must be given to all parent/caretakers who apply for children who have an absent parent (AP). On the "Notice of Cooperation and Good Cause", the applicant/recipient can choose to:

- agree to cooperate with DCSE;
- claim good cause for not cooperating with DCSE ; or in child only cases, refuse to cooperate with DCSE.

The parent/caretaker's choice determines whether additional forms must be completed.

b. Parent/Caretaker Agrees to Cooperate with DCSE

Complete the "Absent Parent/Paternity Information" form #032-03-501 (see M0250, Appendix 3) when the parent/caretaker agrees to cooperate with DCSE. The "Absent Parent/Paternity Information" form is used to provide information that will be beneficial to DCSE in locating the absent responsible person. This form is completed at initial application, when an individual is added to the family or budget unit, and/or at redetermination.

For DCSE to have a "workable case," certain key information must be obtained when completing the form. Key information includes the AP's name, Social Security number, date of birth, current and past addresses, employers, and parent's name and address. When there is no legal parent or acknowledged father and more than one individual is named as a child's parent, refer all named individuals.

When support is received from the absent responsible parent who is married to someone other than the parent filing the Medicaid application and he has requested that his family not be involved, the address where the responsible parent wishes to be contacted should be noted. All future contacts with such absent responsible parent regarding support will be made by DCSE.

If voluntary or court-ordered third party payments such as rent are being made by the absent responsible parent, a notation of such payment must be made on the form.

The agency must complete page 4 of the form and send the completed document to the District DCSE office when the Medicaid application is approved. The full range of DCSE services will be provided to all referred cases unless DCSE is notified that the parent/caretaker elects partial services for the child.

c. Parent/Caretaker Claims Good Cause

The cooperation requirements can be waived when the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can legally assign rights. Good cause exists when the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.

Complete the "Good Cause Determination", #032-03-035 (see M0250, Appendix 2) when the parent/caretaker claims good cause for not cooperating with DCSE. The parent or legal custodian must provide evidence to support the claim to be excused from cooperating.

The local agency may determine that cooperation would be harmful to the child only if one or more of the following circumstances exist:

- anticipation that cooperation will result in physical or emotional harm to the child;
- anticipation that cooperation will result in physical or emotional harm to the parent which would impair the ability to care for the child;
- the child was conceived as a result of rape or incest;
- legal proceedings for the adoption of the child are pending; or

- the parent, assisted by a public or private social services agency, is considering adoptive placement for the child for whom assistance is requested.

Each parent/caretaker who claims to have good cause for not cooperating with DCSE must provide, within 20 days of making the claim, acceptable evidence or sufficient information such as:

- court, medical, criminal, child protective services, psychological, law enforcement records, or written statement from domestic violence or sexual assault crisis center professional indicating the putative father or absent parent might inflict physical or emotional harm on the child or parent;

- birth certificates, medical or law enforcement records in the case of incest or rape; or

- court documents or legal records which indicate legal proceeding for adoption are pending.

In addition to the above evidence, sworn statements from individuals including neighbors, clergymen, social workers, and medical professionals who might have knowledge of the circumstances supporting claims of physical harm can be used to substantiate good cause. This information cannot be the only evidence to support the claim.

On every claim of good cause, the worker will make the final determination that:

- good cause exists and DCSE may not pursue support; or
- good cause does not exist.

When the worker determines good cause exists, the "Absent Parent/Paternity Information" form is not completed, and the parent is not penalized for not cooperating in pursuing support. When the worker determines good cause does not exist, the parent/caretaker is penalized for not cooperating and is not eligible for Medicaid. The "Good Cause Determination" form is used to document the agency finding.

d. Parent/Caretaker Refuses Cooperate

When the parent/caretaker who is required to cooperate refuses or fails to return the completed "Notice of Cooperation and Good Cause", cooperation requirements are not met and the parent/caretaker

is not eligible for Medicaid. The parent/caretaker who is required to cooperate and refuses or fails may choose not to apply for the child or may choose to have the child's Medicaid coverage cancelled so that the parent/caretaker may be eligible for Medicaid for himself/herself. The parent/caretaker's refusal or failure to cooperate does not affect the child's Medicaid eligibility.

2. Child-Only Applicant/ Recipient

When the application is filed on behalf of a child-only and cooperation with DCSE is not a condition of the eligibility, the pursuit of support from absent parent(s) is initiated after the child has been determined eligible and has been enrolled in Medicaid. The "Notice of Cooperation and Good Cause" *and the "Absent Parent/Paternity Information" form*s must be sent with the approval notice for all Medicaid eligible children who have an absent parent. Document in record that *the forms were sent. See I. 1. a. above for a description of "Notice of Cooperation and Good Cause". See I. 1. b. above for instructions for completing the "Absent Parent/Paternity Information" form.*

If the parent wishes to claim good cause for not cooperating, refuses to cooperate, or fails to complete and return the "Notice of Cooperation and Good Cause", no additional forms must be completed. The child remains Medicaid eligible.

J. Communication Between Agency and DCSE

1. Eligibility Worker Responsibilities

The eligibility worker must make every effort to provide DCSE with complete and accurate information. Changes including address, absent parent information, range of service, subsequent good cause determination, and Medicaid eligibility must be reported to DCSE. The "Medicaid Information Transmittal" form #032-11-520 (see M0250, Appendix 4) is used to communicate with DCSE.

2. DCSE Responsibilities

DCSE uses the "Cooperation/Non-cooperation Notification" form #803-11-96 to inform the eligibility worker of the following:

- the client is not cooperating with DCSE and asks if good cause exists;
- no further action on the case is possible without the client's cooperation;
- a recipient has accepted direct payment of child support; or
- DCSE closes the case.

K. Parent/Caretaker Withdrawal From DCSE Services

The parent/caretaker can withdraw from the **full range of services** at any time without penalty. However, in order to meet the cooperation in pursuing paternity and medical support eligibility requirement, he or she cannot withdraw from cooperating with DCSE in pursuit of paternity and medical support without good cause (see I. 1. c. above). If good cause exists, DCSE will close its case upon receipt of such notification from the local DSS. If good cause does not exist, the eligibility worker will determine if the parent/caretaker recipient remains eligible for Medicaid.

L. Medicaid Cancellation & Continued DCSE Services

When a child's Medicaid coverage is cancelled, send a "Medicaid Information Transmittal" form #032-11-520 (see M0250, Appendix 4) to DCSE informing them of the cancellation. DCSE will send the recipient a package of information called the "transition package" which explains DCSE services and explains that support services will continue to be provided unless DCSE is notified to the contrary. DCSE must send a notice to the former recipient within 5 working days of receipt of a notice of ineligibility for Medicaid.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF COOPERATION AND GOOD CAUSE

To be eligible for Temporary Assistance for Needy Families (TANF), you are required by law to cooperate in establishing paternity and/or collecting child support to which you or your child may be entitled.

To be eligible for Medicaid you are required by law to cooperate in establishing paternity and obtaining medical support to which you or your child may be entitled. If you are a pregnant woman, you are not required as a condition of your eligibility:

1) to cooperate in establishing paternity for a child born out of wedlock, or
2) to pursue medical support for yourself or children from the father of a child born out of wedlock.

WHAT IS MEANT BY COOPERATION?

- Providing information about the identity of the father of any child applying for or receiving assistance or, for TANF, identifying all individuals with whom the mother had sexual intercourse who may be the father.
- Providing other information or documentary evidence, as requested, to help establish legal paternity of a child born out of wedlock or locate an absent legal parent.
- Appearing at a local Department of Social Services office, a Division of Child Support Enforcement (DCSE) office, a Medicaid office, Court, or other hearing, or proceeding as requested.
- For TANF, helping establish paternity by keeping scheduled appointments to have blood drawn.
- Helping obtain child support, medical support, or any other money or property owed to you or a child receiving assistance. This includes insurance companies who may be liable to pay for medical services.
- Paying to the DCSE any money directly received from the absent parent after your TANF case has been approved.
- For TANF cases when the child requesting or receiving assistance was born before May 1, 1996, and for all Medicaid cases, providing verbal or written information, as requested, OR stating under penalty of perjury you have no knowledge of the information requested.

WHAT ARE THE BENEFITS OF COOPERATION?

Your cooperation could result in the following benefits:

- Locating an absent parent.
- Legally establishing paternity for a child.
- Obtaining child support that may be higher than your TANF grant or receiving a support disregard payment of up to $50.00 per month in addition to your TANF grant.
- Obtaining rights to future social security, veteran's, or other government benefits, including medical support.

WHAT IS MEANT BY "GOOD CAUSE" FOR NOT COOPERATING?

If you believe that your cooperation would be harmful to you or your child, you may claim good cause for not cooperating. If you can provide evidence to support this claim, you may be excused from cooperating, and no attempt will be made to establish paternity or collect support.

WHAT IF YOU DO NOT COOPERATE AND GOOD CAUSE HAS NOT BEEN DETERMINED?

- You will be ineligible for assistance if you do not cooperate in establishing paternity.
- Your TANF case will be closed if paternity is not established after six months of assistance and you are not cooperating.
- You will be ineligible for assistance but your children will continue to be eligible if you do not cooperate for any other reason, such as failure to keep scheduled appointments, or cooperate in providing information about a legal parent.
- A protective payee may be appointed to receive the TANF check.
- The Department of Social Services may seek support on behalf of eligible children if it is determined that it may be done without risk to you or your children.

WHAT IF YOU CHOOSE TO COOPERATE AND NOT CLAIM GOOD CAUSE?

You may go directly to the end of this notice, check (√) the block indicating you do not wish to claim good cause and will cooperate with DCSE, and sign your name.

WHAT IF YOU WISH TO CLAIM GOOD CAUSE FOR NOT COOPERATING?

- You must identify the parent of any child applying for or receiving assistance or, for TANF, identify all individuals with whom the mother had sexual intercourse who may be the father. After you provide this information, you may claim good cause for not cooperating at any time by telling your worker.
- You must then provide evidence that good cause exists within 20 days after claiming good cause.
- If you need help obtaining the necessary evidence, you may ask your worker for assistance.

WHAT IS GOOD CAUSE AND HOW DO YOU PROVE IT?

- Based on the information you provide and on investigation of your claim, your agency will determine if good cause exists.
- Good cause for not cooperating will be determined to exist **only if:**

You claim good cause for one of these reasons:	**And you provide clear and convincing evidence, such as:**
You anticipate that cooperating will result in physical or emotional harm to you or your child reducing your ability to care for your child.	☼ Court, medical, criminal, child protective services, psychological, or law enforcement records or a written statement from a domestic violence services program or sexual assault crisis center professional indicating the alleged or absent father might inflict physical or emotional harm on you or the child. ☼ Medical records which indicate the emotional health history and present health status of you or the child for whom support would be sought. ☼ A written statement from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of you or the child.
The child was conceived as a result of forcible rape or incest.	☼ Birth certificates or medical or law enforcement records that indicate the child was conceived as the result of forcible rape or incest.
Legal proceedings are going on for adoption of the child.	☼ Court documents or other records which indicate that legal proceedings for adoption are pending in court. ☼ A written statement from a public or private agency confirming that you are being assisted in resolving the issue of whether to keep or give up the child for adoption.

NOTE: In addition to the above evidence, you may offer a sworn statement from individuals including neighbors, clergymen, social workers, and medical professionals who might have knowledge of the circumstances supporting your good cause claim of physical harm. This information cannot be the only evidence offered to support your claim.

WHAT HAPPENS AFTER A DETERMINATION IS MADE?

- You will be notified of the results of the agency's investigation and whether or not good cause for not cooperating exists.
  If good cause exists, no attempt will be made to establish paternity or collect support.
  If good cause does not exist, you will be required to cooperate with your agency and the DCSE, unless you withdraw your application or request that your case be closed.
- The DCSE and the State Medicaid Office may review the determination.
- You may request a hearing if you disagree with the determination. The DCSE and State Medicaid Office may participate in the hearing.
- Your good cause claim will be reviewed periodically to determine if good cause continues to exist.

- I understand that the requirements for establishing paternity and pursuing support are different for Medicaid and TANF.

- I have read this notice and understand my right to claim good cause for refusing to cooperate.

Please check (√) one of the boxes.

- ☐ I do not wish to claim good cause and will cooperate with DCSE.
- ☐ I wish to claim good cause for not cooperating with DCSE.
- ☐ I am applying for Medicaid for children only and refuse to cooperate with DCSE.

_____ _____
Signature of Applicant/Recipient Date

I have provided the applicant/recipient with a copy of this notice.

_____ _____
Signature of Worker Date

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

GOOD CAUSE DETERMINATION

I. IDENTIFYING INFORMATION

CASE NAME	DATE	VACIS CASE NUMBER
ADDRESS	LOCALITY	
CITY, STATE, ZIP	WORKER	
RESPONSIBLE PERSON	CHILDREN INVOLVED	RESPONSE DUE (IF APPLICABLE)

II. GOOD CAUSE CLAIM BASED ON

☐ ANTICIPATION THAT COOPERATION WILL RESULT IN

- ☐ PHYSICAL HARM TO CHILD
- ☐ EMOTIONAL HARM TO CHILD
- ☐ PHYSICAL HARM TO CARETAKER
- ☐ EMOTIONAL HARM TO CARETAKER

☐ CHILD WAS CONCEIVED AS A RESULT OF INCEST
☐ CHILD WAS CONCEIVED AS A RESULT OF FORCIBLE RAPE
☐ PENDING LEGAL ADOPTION PROCEEDINGS
☐ ADOPTION CONSIDERATION CURRENTLY BEING MADE
☐ FOSTER CARE CASE - SERVICE PLAN INCLUDES RETURN OF CHILD TO PARENT (DOES NOT APPLY TO TITLE XXI)

III. EXPLANATION OF EVIDENCE USED TO SUBSTANTIATE CLAIM

IV. EVIDENCE USED WAS	V. DETERMINATION
☐ PROVIDED BY CUSTOMER ☐ OBTAINED BY WELFARE/SOC. SER. DEPT. ☐ COMBINATION OF BOTH ABOVE	☐ GOOD CAUSE IS BEING CLAIMED - DETERMINATION IS PENDING ☐ GOOD CAUSE EXISTS - DCSE MAY NOT PROCEED ☐ GOOD CAUSE DOES NOT EXIST

DCSE USE ONLY

☐ DCSE DOES NOT CONCUR
☐ REASONS OR COMMENTS

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES

ABSENT PARENT/PATERNITY INFORMATION

CREATE NEW_____ OR UPDATE_____

MUST HAVE VACIS CASE # FOR CREATE OR ANY OF *FIELDS FOR UPDATE 6 NEW AP FOR EXISTING CASE:_____

1 *VACIS CASE#:	2 *APID#:	3 *MPI#:	4 *SSN#:
5 *CHILD CLIENT ID#:			
7 *ABSENT PARENT LAST NAME:	FIRST:		MIDDLE:
ALIAS NAME: LAST	FIRST:		MIDDLE:
8 ADDRESS:	9 WHEN CURRENT:		
10 CITY:	11 STATE:	12 ZIP:	
13 COUNTRY:	14 FOREIGN POSTAL CODE:		
4 SSN: / 15 DOB:	16 AGE:	**17 SEX:**	18 RACE:
19 BIRTH CITY/20 STATE/21 COUNTRY:	22 TELEPHONE#:		
23 GOOD CAUSE:	**24 AP CURRENT RELATIONSHIPTO CASE NAME:**		
ABSENT PARENT OCCUPATION DATA			
25 OCCUPATION:	26 EMPLOYER:		
27 AS OF DATE:	28 ADDRESS:		
29 TELEPHONE:	30 CITY:	31 STATE:	
32 ZIP:	**33 DOES ABSENT PARENT RECEIVE BENEFITS? YES NO UNKNOWN**	34 IF YES, WHICH TYPE:	

ABSENT PARENT MILITARY DATA		
35 BRANCH:	36 STATUS:	37 END DATE:
ABSENT PARENT BANK DATA		
38 BANK:	39 ACCOUNT#:	

NOTES:

BOLD FIELDS ARE REQUIRED FIELDS.

DOUBLE ASTERISK FIELD (**) DATA IS TO BE ENTERED IN COMMENT AREA OF MAPPER 501 SYSTEM.

032-03-501/4 (7/02)

ABSENT PARENT MOTOR VEHICLE/DRIVER'S LICENSE DATA			
40 VEHICLE LICENSE NUMBER	41 STATE	**MAKE:	**MODEL:
**DRIVER'S LICENSE NUMBER IF DIFFERENT THAN SSN:			
ABSENT PARENT CRIME/CONVICTIONS DATA			
42 ANY CRIME/CONVICTIONS?	43 TYPE:	44 ENTER JAIL DATE:	
45 JAIL CITY/COUNTY:	46 STATE:		
47 IS ABSENT PARENT CURRENTLY ON PROBATION OR PAROLE?			
ABSENT PARENT FATHER/MOTHER DATA			
48 FATHER'S LAST NAME:	FIRST:	MIDDLE:	
49 ADDRESS:			
50 TELEPHONE #:	51 CITY	52 STATE:	53 ZIP:
54 COUNTRY:	55 FOREIGN POSTAL CODE:		
56 MOTHER'S LAST NAME:	FIRST:	MIDDLE:	
57 ADDRESS:			
TELEPHONE #:	CITY	STATE:	ZIP:
COUNTRY:	FOREIGN POSTAL CODE:		
ABSENT PARENT EMERGENCY CONTACTS			
58 LAST NAME:	FIRST:	MIDDLE:	
59 ADDRESS:	60 RELATIONSHIP: 61 TELEPHONE #:		
62 CITY:	63 STATE:	64 ZIP:	
LAST NAME:	FIRST:	MIDDLE:	
ADDRESS:	RELATIONSHIP: TELEPHONE #:		
CITY:	STATE:	ZIP:	
LAST NAME:	FIRST:	MIDDLE:	
ADDRESS:	RELATIONSHIP: TELEPHONE #:		
CITY:	STATE:	ZIP:	

NOTES: **BOLD FIELDS ARE REQUIRED FIELDS.** DOUBLE ASTERISK FIELD (**) DATA IS TO BE ENTERED IN COMMENT AREA OF MAPPER 501 SYSTEM.

**ABSENT PARENT - SCHOOLS ATTENDED		
**SCHOOL NAME:	**LOCATION:	**WHEN ATTENDED:
**SCHOOL NAME:	**LOCATION:	**WHEN ATTENDED:
**ABSENT PARENT - PLACES OF SOCIAL CONTACT		
**		**

65 MEM#	66 CHILD'S BIRTH CITY	67 CHILD'S BIRTH STATE	68 PAT. ACK.	69 DOES AP HAVE MED. INS. FOR CHILD(REN)	70 INS. NAME INS. #	71 COURT NAME	72 COURT ORDER #	73 TERMS 74 TYPE	75 COURT EFF. DATE	76 AMOUNT ORDERED

MEM#	77 LAST AMOUNT PAID	78 LAST AMT. PAID DATE	79 PAYMENT FREQUENCY	80 PAID TO:	81 MULTIPLE ORDERS	MOTHERS MARITAL ST. AT CHILD'S BIRTH

NOTES:

BOLD FIELDS ARE REQUIRED FIELDS.

DOUBLE ASTERISK FIELD (**) DATA IS TO BE ENTERED IN COMMENT AREA OF MAPPER 501 SYSTEM.

I certify that the information given is true and accurate to the best of my knowledge.

Recipient/Custodial Parent Signature_____

DIVISION OF CHILD SUPPORT ENFORCEMENT SERVICES REFERRAL

AGENCY USE ONLY		
Program Code (Put Code Below for Each Child) 1 = AFDC/FC Non-Maintenance Child Case 2 = Medicaid Case	Locality Name/FIPS	
	Locality Case Number	
	Worker Name/Telephone Number	
	DCSE Case Number	Date

Applicant/Custodial Parent/Custodial Agency Information

Name (Last, First, Middle)	Date of Birth	SSN	Sex	Race
Mailing Address	City/Town	State/Zip	Home Phone #	
Employer Name, Address, Employer's Phone #				

Code	Child's Name	Child's Social Security Number	Child's Date of Birth	Relationship to Applicant

Division of Child Support Enforcement (DCSE) Services

I have elected to cooperate or must cooperate as a condition of my Medicaid eligibility with DCSE. Medicaid recipients are entitled to receive full services, but may choose to receive the partial services described below.

DCSE Full Services:

- locating any legal/potentially legal parent of the child and the source/location of income/assets.
- establishing paternity, if needed, for the child born during a time when the parents were not married.
- establishing, enforcing and collecting for you and the child current or past due support, including medical support, from anyone who has a legal duty to support the child.
- endorsing and cashing checks and money orders or other forms of payment which are made out to you for support payments, issuing you checks from the State Treasurer, and providing receipts to the payor.

DCSE Partial Services:

DCSE will not pursue financial support but will pursue medical support, which may involve locating absent parents and establishing paternity (as shown above).

I only want partial services for _____.
(Name of Child)

Note: Child Support services will continue after a Medicaid case closes unless the recipient of services requests that DCSE close the case.

Applicant/Custodial Parent/Custodial Agency Signature: _____ Date: _____

Appendix 5: ABSENT PARENT/PATERNITY INFORMATION

FORM NUMBER - 032-03-501

PURPOSE

1. To report to the Division of Child Support Enforcement (DCSE) all identifying information regarding each absent responsible person to aid in securing medical and financial support, establishing paternity, for Medicaid children.

2. To notify DCSE of the child's Medicaid status.

USE OF FORM - Completed for Medicaid eligible children, except for the child(ren) whose absent parent is deceased and the child(ren) whose custodial parent has established good cause for noncooperation with DCSE, or when TANF has referred the case.

NUMBER AND DISTRIBUTION OF COPIES - Prepare original; make copy for agency record before sending original to DCSE.

INSTRUCTIONS FOR PREPARATION OF FORM - Information regarding the absent responsible parent and the child(ren) for which he/she is responsible is listed on pages 1-3. Information regarding the applicant/custodial parent/custodial agency and the child(ren) and the selection of services is on page 4. If the DCSE does not have an open case for the child(ren), pages 1-4 must be completed and sent to DCSE. If DCSE has an open case for the child(ren), only page 4 of the form must be completed and sent to DCSE.

FACE-TO-FACE INTERVIEW -When having a face-to-face interview, the eligibility worker should complete this form with the assistance of the applicant/custodial parent/custodial agency. The applicant/custodial parent/custodial agency must be advised of what he/she is attesting to or requesting when signing the certification and authorization statements.

NO FACE-TO-FACE INTERVIEW- In the absence of a face-to-face interview, the form can be completed by the applicant/custodial parent/custodial agency and sent to the department of social services.

If the applicant/custodial parent/custodial agency refuses to complete and return the form and the child(ren) meet all other Medicaid eligibility requirements, the eligibility worker must complete and sign the form prior to making the DCSE referral.

Commonwealth of Virginia
Department of Social Services

MEDICAID INFORMATION TRANSMITTAL

TO:	FROM:
NONCUSTODIAL PARENTS:	NCP SSN:
RECIPIENT/CUSTODIAL PARENT:	MEDICAID #:
DEPENDENT:	DEPENDENT SSN:
MESSAGE:	
SIGNED:	DATE:
TELEPHONE#: ( )	

TO:	FROM:
REPLY:	
SIGNED:	DATE:
TELEPHONE#: ( )	

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 60

RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 70

APPLICATION FOR OTHER BENEFITS

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0270.000 APPLICATION FOR OTHER BENEFITS

	Section	Page
General Principle	M0270.100	1
Types of Benefits	M0270.200	2
Agency Procedures	M0270.300	3

M0270.000 APPLICATION FOR OTHER BENEFITS

M0270.100 GENERAL PRINCIPLE

A. Policy

Because Medicaid is a "last pay" medical assistance program, it is important that the individual and agency worker assess the other benefits for which an individual is eligible based on his or her own activities or based on indirect qualification through family circumstances.

As a condition of eligibility, an individual must take all necessary steps to apply for and obtain any annuities, pensions, retirement, and disability benefits to which he/she is entitled, unless he/she can show good cause for not doing so.

1. Steps to Pursue Other Benefits

An individual must take all appropriate steps to pursue eligibility for other benefits. This includes

- applying for the benefit, and
- providing the source of the other benefit with the necessary information to determine the individual's eligibility for the benefit.

2. Refusal To Apply

Refusal to apply for a benefit or refusal to accept a benefit to which the individual is entitled will result in the inability of a local agency to determine the individual's Medicaid eligibility.

In the case of a minor or an incapacitated individual, a parent or other responsible person must pursue benefits for which the minor or the incapacitated individual might be entitled. If such benefits are not pursued, eligibility must be denied.

A non-applicant parent or spouse cannot be required to apply for any benefit on their own behalf. A child's or spouse's Medicaid eligibility cannot be denied due to the failure of the non-applicant parent or spouse to apply for or accept a benefit for which the non-applicant parent or spouse might be entitled.

3. Good Cause For Not Applying

An individual meets this requirement for Medicaid, despite failure to apply for other benefits or take other steps necessary to obtain them, if the individual has good cause for not doing so. For example, good cause exists if:

- the individual is unable to apply for other benefits because of illness;
- it would be useless to apply because the individual had previously applied and the other benefit source turned him down for a reason(s) that has not changed;
- it would result in no additional benefit which would affect the individual's Medicaid eligibility or amount of Medicaid services.

B. Procedure

The types of benefits for which an individual must apply and/or accept are listed in section M0270.200 below.

The procedures to follow are in section M0270.300 below.

M0270.200 TYPES OF BENEFITS

A. Benefits Excluded From Requirement to Apply

An applicant is NOT required to apply for benefits or assistance that is based on the individual's need. An individual is not required to apply for cash assistance program benefits such as Supplemental Security Income (SSI) or Temporary Assistance For Needy Families (TANF).

Payments such as child support, alimony, accelerated life insurance, etc., are NOT benefits for which an individual must apply.

B. Types of Benefits For Which An Individual Must Apply

1. Benefit Characteristics

Benefits for which the individual must apply have the following characteristics in common:

- require an application or similar action;
- have conditions for eligibility;
- make payments on an ongoing or one-time basis.

2. Major Benefit Programs

Annuities, pensions, retirement and disability benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

a. Veterans' Compensation and Pensions, including apportionment of augmented dependents' benefits;

b. Social Security Title II Benefits (OASDI - Old Age, Survivors & Disability Insurance)

c. Railroad Retirement Benefits

d. Unemployment Compensation

e. Worker's Compensation

f. Black Lung Benefits

g. Civil Service and Federal Employee Retirement System Benefits

h. Military Pensions

3. Other Benefits

Other benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

a. private insurance company disability, income protection, etc., benefits when the individual has such a policy;

b. private pension plan benefits;

c. union benefits.

M0270.300 AGENCY PROCEDURES

A. Written Notice

The local agency Eligibility Worker (EW) must advise the individual in writing on a dated notice that the individual must apply for other benefits for which he or she is potentially eligible. The written notice must list the benefits for which the individual must apply.

B. Identify Potential Eligibility For Other Benefits

Obtain clues to an individual's possible eligibility for other benefits from:

- information obtained from the interview, including responses to leading questions on the application;
- the recipient's responses on a redetermination form and/or interview;
- inquiries received from another agency;
- agency knowledge of pension plans and benefits;
- third party reports;
- computer system inquiries.

C. Disability Referral Processing

Do not hold the *Disability Determination Services (DDS)* referral while waiting for the applicant to provide proof of his/her application for disability benefits; send it immediately to the *DDS.*

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 80

INSTITUTIONAL STATUS REQUIREMENTS

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

	Section	Page
General Principles	M0280.001	1
Definition of Terms	M0280.100	1
Institutional Status Rule	M0280.200	3
Individuals In Medical Facilities	M0280.201	3
Individuals In Residential Facilities	M0280.202	4
Inmate of A Public Institution	M0280.300	5
Who Is NOT An Inmate of A Public Institution	M0280.301	7
Procedures For Determining Institutional Status	M0280.400	9
Individuals Moving To or From Public Institutions	M0280.500	10
Departmental Responsibility	M0280.600	11

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0280.001 GENERAL PRINCIPLES

A. Introduction

To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution to be considered an "inmate of a public institution." Inmates of public institutions are NOT eligible for Medicaid.

B. Procedure

This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

M0280.100 DEFINITION OF TERMS

A. Child Care Institution

A child care institution is a

- non-profit private child-care institution, or
- a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

B. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

C. Institution

An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

D. Institution for the Treatment of Mental Diseases (IMD)

An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. An facility for the mentally retarded is NOT an IMD.

E. Medical Facility

A medical facility is an institution that:

- is organized to provide medical care, including nursing and convalescent care,

- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,

- is authorized under state law to provide medical care, and

- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

F. Public Institution (Facility)

A public institution is a institution (facility) that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, and which is NOT a medical facility.

The following are NOT public facilities for this section's purposes:

- a medical facility, including a nursing facility;

- a publicly operated community residence (serves no more than 16 residents);

- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that accomodates no more than 25 children;

- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

G. Publicly Operated Community Residence

A publicly operated community residence is a public residential facility (institution) with 16 beds or less, that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;

- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;

- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent;

- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence.

H. Residential Institution

An institution that does not meet the definition of a "medical facility."

M0280.200 INSTITUTIONAL STATUS RULE

A. Introduction

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

1. individuals who are **inmates of a public institution**.

2. individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. NOTE: an ICF-MR is not an IMD.

B. Procedures

The policy and procedures for determining whether an individual is in an IMD are contained in subchapter M1430.

The policy and procedures for determining whether an individual is an inmate of a public institution are contained in the following sections:

- M0280.201 Individuals in Medical Facilities
- M0280.202 Individuals in Residential Facilities
- M0280.300 Inmate of A Public Institution
- M0280.301 Who Is NOT An Inmate of A Public Institution
- M0280.400 Procedures For Determining Institutional Status
- M0280.500 Individuals Moving To or From Public Institutions
- M0280.600 Departmental Responsibility.

M0280.201 INDIVIDUALS IN MEDICAL FACILITIES

A. Individual in a Medical Facility

An individual who lives in a medical facility that is not an IMD may be an inmate of a public institution because he/she is incarcerated or is a juvenile in detention, as defined in this subchapter. If the individual is incarcerated or is a juvenile in detention, he is not eligible for Medicaid.

B. Institutions With Medical and Residential Sections

Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility.

C. Public or Private

The public or private ownership or administration of a **medical** facility is irrelevant because a medical facility is not a public institution as defined in this subchapter.

D. Cross Reference

If the individual has been, or is expected to be, in the medical facility or medical section of the facility for 30 or more consecutive days, the individual is receiving long-term care. Go to subchapter M1430 to determine the individual's institutional status.

M0280.202 INDIVIDUALS IN RESIDENTIAL FACILITIES

A. Institutions With Medical and Residential Sections

1. Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility. If the individual has been, or is expected to be, in the medical facility for 30 or more consecutive days, the individual is receiving long-term care. Go to New Volume XIII Chapter M1400 to determine the individual's eligibility.

2. An individual in the residential portion (or beds) of the institution is a resident of a residential facility. Use this subchapter to determine the resident's institutional status.

B. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. **A group home that has three or less residents is not an institution.**

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

C. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

D. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

1. the public residential facility has more than 16 beds, or

2. the individual is an inmate - an incarcerated adult or a juvenile in detention - as described in section M0280.300 below, and is not an individual listed in M0280.301 below.

M0280.300 INMATE OF A PUBLIC INSTITUTION

A. Policy

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated individuals;
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. For example, an individual released from jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is still considered incarcerated and is an inmate of a public institution. An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

1. District or County Homes

The District Homes or County Homes are public residential facilities that serve more than 16 residents. A District or County home may have other portions of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas. There is one county home - the Orange County Home.

Residents in the residential portions of the District or County Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public institution of more than 16 beds and does not meet the definition of a publicly operated community residence.

Patients in the certified nursing facility portion of the District or County Home are NOT inmates of a public institution because that portion is a medical facility. Patients in the nursing facility portion of the District or County Home meet the institutional status requirement and may be eligible for Medicaid.

2. Ineligible Public Residential Facilities

A public residential facility that does not meet the definition of a "publicly operated community residence" in section M0280.100 above, is an "ineligible public institution." Public residential institutions with more than 16 beds are ineligible public institutions. The following public institutions are ineligible public institutions even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;

- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;

- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent.

C. Incarcerated Individuals

An incarcerated individual is an inmate of a public institution, even when he/she is in a medical facility. The key element is whether the incarcerated individual resided in a jail or prison immediately prior to admission to the medical facility. The following incarcerated individuals are inmates of a public institution:

1. Prison Inmate

An inmate in a prison is not eligible for Medicaid.

2. Jail Inmate

An inmate in a county or city jail is not eligible for Medicaid.

3. Prison or Jail Inmate

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid. An inmate may be eligible if he/she is out on bail or released on his/her own recognizance.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and is not eligible for Medicaid.

4. Work Release

An individual who is incarcerated but can leave the prison, jail or work release center on work release or work furlough and must return to prison or jail at specific intervals is NOT eligible for Medicaid.

5. Released on Medical Emergency

An individual released from prison or jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is not eligible for Medicaid.

D. Juveniles in Detention

In determining whether a juvenile (individual under age 18 years) is incarcerated and an inmate of a public institution, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

1. Prior to Court Disposition

1) A juvenile who is in a detention center due to criminal activity is an inmate of a public institution. Incarceration in a detention center due to criminal activity makes the individual an inmate of a public institution. The length of stay in the detention center is irrelevant. A short incarceration in a detention facility is NOT temporary placement pending other arrangements.

A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution.

2) A juvenile who is in a detention center due to care, protection or in the best interest of the child is NOT an inmate of a public institution.

2. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. If they go to a nonsecure group home, they are NOT inmates of a public institution because a nonsecure group home is not a detention center.

3. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of an ineligible public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid.

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

a. A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity is not eligible for Medicaid.

b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

M0280.301 WHO IS NOT AN INMATE OF A PUBLIC INSTITUTION

A. Educational or Vocational Institution

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

B. Temporary Stay

An individual residing in a public institution for a temporary period pending other arrangements appropriate to his needs is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

C. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

D. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard is NOT an inmate of a public institution and may be eligible for Medicaid.

E. Inmate Out On Bail

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid unless he/she is out on bail or released on his/her own recognizance.

F. Probation, Parole, or Conditional Release

An individual released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency is NOT an inmate of a public institution and may be eligible for Medicaid.

G. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgement) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

H. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

I. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient is NOT an inmate of a public

institution and may be eligible for Medicaid.

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is NOT eligible for Medicaid.

M0280.400 PROCEDURES FOR DETERMINING INSTITUTIONAL STATUS

A. Procedures

In this order, determine:

B. Is the Individual In An Institution?

Ask: is the individual living in a home or establishment that provides food, shelter and some services to four or more persons unrelated to the proprietor?

1. If NO, the individual is not in a facility. Individual meets the institutional status eligibility requirement for Medicaid. STOP.

2. If YES, the individual is in a facility. Go to item C. below.

C. Is the Facility Medical?

Ask: is the institution, or portion of the institution, in which the individual resides a medical facility?

1. If NO, the facility is residential. Go to item D. below.

2. If YES, the individual is in a medical facility. Go to subchapter M1430.

D. Is the Individual in a Public Institution?

Determine if the residential facility is a public institution as defined above. Ask: is the residential facility public?

1. If NO, go to item E. below (determine if the individual is incarcerated and an inmate of public institution).

2. If YES, ask: how many beds does it have?

   a. If it has 16 beds or less, go to item E. below (determine if the individual is incarcerated and an inmate of public institution).

   b. If it has more than 16 beds, the individual DOES NOT meet the institutional status requirement and is not eligible for Medicaid. STOP.

E. Is the Individual An Inmate of a Public Institution?

Is the individual incarcerated and an inmate of a public institution? Ask the following questions:

1. Was he in a secure facility (jail, prison, secure detention) immediately before admission?

a. If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

b. If YES, ask: is he a juvenile (under age 18)?

1) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

2) YES: Ask: Is this facility a secure treatment facility?

a) NO: Ask: Was he in a juvenile detention center prior to admission due to criminal activity?

(1) NO: he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

(2) YES: Ask: Was he placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient?

(a) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

(b) YES: he is not an inmate of a public institution and may be eligible for Medicaid. STOP.

b) YES: Ask: Is the secure treatment facility part of the criminal justice system?

(1) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. STOP.

(2) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

M0280.500 INDIVIDUALS MOVING TO OR FROM PUBLIC INSTITUTIONS

A. Moves To Public Institution

If a currently eligible recipient is incarcerated or enters an ineligible institution, he is no longer eligible for Medicaid. Outstanding bills for covered medical services incurred prior to his admission and during his Medicaid coverage period will be paid.

B. Moving From Public Institution

Although a person may not be eligible for Medicaid while living in a specified public institution or part thereof, he may apply for such assistance as a part of prerelease planning. If he is found eligible (except for institutional status), do not enroll until he leaves the institution to live elsewhere.

C. Resident Admitted to Medical Facility

A resident of an ineligible public institution, or an inmate of a public institution, who is admitted to a medical institution (general hospital or nursing facility) for inpatient care is NOT eligible for Medicaid during the period of care in the medical institution because his institutional status does not change when he is admitted to the medical facility. He is still considered an inmate of a public institution.

M0280.600 DEPARTMENTAL RESPONSIBILITY

A. DMHMRSAS Patients

1. ABD Covered Groups

Medicaid eligibility of patients who are:

- in State-owned Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental disease and mental retardation,
- not currently enrolled in Medicaid, and
- eligible in an Aged, Blind, or Disabled (ABD) covered group

is determined by the Medicaid Technician staff of the Division of Temporary Assistance Programs, Department of Social Services, who also carries responsibility for enrollment. (See subchapter M1550).

2. F&C DMHMRSAS Patients

Local social services departments continue to carry responsibility for the determination of eligibility for Medicaid of a child eligible in a Families and Children's covered group who have been admitted to a DMHMRSAS institution for treatment of the mentally retarded, and for the child's enrollment in Medicaid.

B. All Other Institutions

Local social services departments carry responsibility for the Medicaid eligibility determination and enrollment of individuals in institutions that are not operated by DMHMRSAS. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

When a local department carries responsibility for eligibility determination and enrollment of an individual living in an institution, the department is also responsible for:

1. advising the institution of the individual's eligibility for Medicaid and enrollment in the program;
2. submitting a form DMAS-122 to the institution to indicate current patient pay, if applicable;
3. seeing that the Medicaid card is forwarded to the institution for the recipient’s use.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 90

HIPP REQUIREMENTS

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0290.000 HIPP REQUIREMENTS

	Section	Page
General Principles	M0290.001	1
Definition of Terms	M0290.100	1
HIPP Requirements	M0290.200	2

M0290.000 HIPP REQUIREMENTS

M0290.001 GENERAL PRINCIPLES

A. Introduction To be eligible for Medicaid, certain individuals must meet the Health Insurance Premium Payment Program (HIPP).

B. Procedure The definitions of terms used in this subchapter are in section M0290.100 below.

The HIPP requirements are in section M0290.200 below.

M0290.100 DEFINITIONS

A. Assistance Unit means *the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for Families & Children (F&C) covered groups is called the "family unit" or the "budget unit".*

The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD. In this situation, the assistance unit is the married ABD couple.

B. HIPP means the Health Insurance Premium Payment Program. HIPP is a cost-saving program administered by the Department of Medical Assistance Services (DMAS) for Medicaid recipients, which pays the employee portion of the group health insurance premium for recipients who have private health insurance available to them through their own or their family member•s employment.

M0290.200 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP) REQUIREMENTS

A. Policy As a condition of Medicaid eligibility, any individual who

- is eligible for Medicaid,
- is a member of an assistance unit which contains an individual employed more than 30 hours per week, and
- is eligible for coverage under an employer's group health plan

must complete the HIPP Application Form and the Medical History Questionnaire, and submit the Insurance Verification Form to the employer.

If DMAS determines that enrollment of the individual in the group health plan is cost-effective; the individual must enroll in the group health plan

in order to remain eligible for Medicaid.

Under this program, DMAS provides payment of the employee's portion of the group health insurance premium. The HIPP Program may pay for the premiums for non-Medicaid eligible family members if they must be enrolled in order for Medicaid-eligible family members to obtain the health plan coverage.

B. Individuals Who Will Not Be Considered for HIPP

The following individuals will not be considered for HIPP unless extraordinary circumstances indicate the group health plan might be cost-effective:

1. Individuals eligible for Medicaid after meeting a spenddown;
2. Individuals eligible for retroactive Medicaid only;
3. Individuals in a nursing facility or who have a deduction from patient pay responsibility to cover the insurance premium;
4. Individuals eligible for or enrolled in Medicare Part B;
5. Individuals who are absent parents; or
6. Individuals with CHAMPUS policies.

C. Individuals with Special Medical Conditions

An individual described in B. above may be considered for HIPP if he has a medical condition that requires ongoing treatment and the group health insurance plan might be cost-effective. Contact the HIPP Unit for guidance on situations requiring special consideration.

An individual who has a medical condition requiring ongoing treatment and who has any insurance coverage available (whether or not it is through an employer group), may submit a HIPP Application to the HIPP Unit at DMAS. The HIPP Unit will verify insurance coverage with the company and determine if Medicaid payment of the premiums would be cost-effective.

D. Failure to Cooperate

If an individual, without good cause, fails to complete either the HIPP Application or Medical History Questionnaire, or fails to enroll in a cost-effective group health plan, the individual loses eligibility for Medicaid. An "Advance Notice of Proposed Action" must be sent prior to canceling coverage. Non-cooperation of a parent or spouse does not affect eligibility for Medicaid benefits for the individual's spouse or child.

E. Good Cause For Failure to Cooperate

Good cause for failure to cooperate shall be established when the recipient, parent, spouse, or person acting on behalf of the recipient demonstrates one or more of the following conditions:

1. There was a serious illness or death of the parent, spouse, or a member of the parent's family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The parent or spouse offers a good cause beyond the parent's or spouse's control.

4. There was a failure to receive DMAS's request for information or notification for a reason not attributable to the parent or spouse. Lack of a forwarding address is attributable to the parent or spouse.

5. The required information on the group health plan could not be obtained from the employer.

6. The recipient demonstrates a medical need for a specific coverage provided by an available group health plan which does not meet the DMAS established cost-effectiveness criteria. This specific coverage is not provided by Medicaid or other group health plans which do meet the DMAS established cost-effectiveness criteria.

F. Disenrollment from a Group Health Plan

If an individual disenrolls from a group health plan which DMAS has determined to be cost-effective, or fails to pay the premium to maintain the group health plan, the individual loses eligibility for Medicaid. An Advance Notice of Proposed Action must be sent prior to canceling coverage.

G. HIPP Application Process

Each applicant or recipient who reports that a member of his assistance unit is employed more than 30 hours each week *and is eligible for coverage under an employer's group health plan* must be given the HIPP Fact Sheet and must complete the HIPP Application and Medical History Questionnaire. The applicant or recipient must be given the Insurance Verification Form to be given to the employer. The employer is to return the Insurance Verification Form to the HIPP Unit at DMAS.

If the applicant or recipient reports that the employer does not offer a group health plan or the individual is not eligible for coverage under the employer's group health plan, do not obtain the HIPP Application and Medical History Questionnaire or require the applicant/recipient to give the Insurance Verification Form to the employer.

1. Copy Insurance Card

If the applicant or recipient is already enrolled in the employer's group health plan, make a copy of the insurance card.

2. If Recipient Is Eligible, Send To HIPP Unit

If the applicant is determined to be eligible for Medicaid or the recipient is determined to remain eligible for Medicaid, complete the enrollment procedures in MMIS. Send the HIPP application, the Medical History Questionnaire, and the copy of the insurance card (if already enrolled in a group health plan) to the HIPP Unit, Department of Medical Assistance Services, Suite 1300, 600 E. Broad Street, Richmond, VA 23219.

Retain a copy of the HIPP application in the case record.

3. HIPP Unit Actions

The HIPP Unit will notify the recipient and DSS of the decision on cost-effectiveness of the group health plan and premium payment.

If the recipient is approved for HIPP payment of the group health plan premium and the recipient was not previously enrolled in the group health plan, the TPL information in MMIS will be updated by DMAS.

Payment will be made to the recipient for the employee's part of the insurance premium. **Payments to the recipient from the HIPP Program are not income to the assistance unit.**

H. Notice of Non-cooperation

The HIPP Unit will notify the agency if the recipient has not cooperated in enrolling in the cost-effective group health plan or paying the premiums to maintain enrollment in the group health plan. Upon receipt of this notification, if good cause for non-cooperation cannot be established, the agency must mail an "Advance Notice of Proposed Action" giving adequate notice of the cancellation of the non-cooperating individual's Medicaid coverage.